Health & Families Council

Monday, April 10, 2006
1:00 PM – 3:00 PM
Reed Hall

Meeting Packet

Allan G. Bense
Speaker

Anna Holliday "Holly" Benson
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health & Families Council

Start Date and Time:	Monday, April 10, 2006 01:00 pm
End Date and Time:	Monday, April 10, 2006 03:00 pm
Location:	Reed Hall (102 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 21 CS Social Status of African-American Men and Boys by Peterman
HB 67 Automated External Defibrillator Devices by Sobel
HB 93 CS Automated External Defibrillators by Henriquez
HB 111 Defibrillators in State Parks by Anderson
HB 127 CS Immunizations by Hays
HB 181 CS Administration of Medication by Hays
HB 599 Florida Faith-based and Community-based Advisory Board by Cannon
HB 859 CS Probable Cause Panels by Baxley
HB 903 CS Pharmacy Common Databases by Traviesa
CS/SB 1838 Pharmacy Common Databases by Health Care, Haridopolos
HB 1067 CS State Long-Term Care Ombudsman Program by Grimsley
HB 1157 CS Dental Charting by Mayfield
HB 1293 CS Medical Malpractice Insurance by Grant
HB 1411 Public Records by Benson
HB 1561 CS Expert Witnesses by Brummer
HB 7125 Medical Records by Health Care Regulation Committee

Pursuant to Rule 7.22(c), amendments by non-appointed members must be filed by 5:00 p.m., Friday, April 7, 2006.

The Chair requests that members of the Council file amendments by 5:00 p.m., Friday, April 7, 2006.

NOTICE FINALIZED on 04/06/2006 15:29 by ISEMINGER.BOBBYE

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 21 CS Social Status of African-American Men and Boys
SPONSOR(S): Peterman and others
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 436

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	7 Y, 0 N, w/CS	Davis	Collins
2) Criminal Justice Appropriations Committee	4 Y, 0 N	Sneed	DeBeaugrine
3) Health & Families Council		Davis	Moore
4)			
5)			

SUMMARY ANALYSIS

HB 21 CS creates a 19-member Council on the Social Status of African-American Men and Boys to make a systematic study of the conditions affecting African-American men and boys, including, but not limited to, the homicide rates, arrest and incarceration rates, poverty, violence, drug abuse, death rates, disparate annual income levels, school performance in all grade levels including postsecondary levels, and health issues.

The members of the council shall consist of legislators, various government officials, and persons appointed by the Speaker of the House of Representatives, President of the Senate, and the Governor, and shall be administratively staffed by the Office of the Attorney General.

The council shall issue its first annual report by December 15, 2007, and by December 15 of each following year, stating the findings, conclusions, and recommendations of the council.

The Attorney General's Office states the need for three FTEs and $182,751 in recurring general revenue funds to provide for the administrative staffing and expenses of the commission. This bill provides no staff positions or funding.

This act shall take effect July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited Government: This bill creates an additional advisory board.

B. EFFECT OF PROPOSED CHANGES:

Present Situation:

Some observers claim that the social status of African-American men and boys has declined over the last decade, and is a cause for great concern throughout society. According to the bill sponsor, the effects of social policy as they relate to African-American males, have a direct impact on the lives of all Florida citizens. Therefore, he feels that the social status of African American males must be improved. The social issues that the sponsor feels require the most urgent attention include:

- Physical and Mental Health: According to the Harvard Medical School's Consumer Health Information Center, black men live an average of 7.1 years less than other racial groups. Almost 12% of African-American males suffer from depression and less than 16% of black men seek needed mental health treatment.
- Unemployment: According to the Alternative School Network, over the past five years, one in every four black men in the United States was permanently unemployed, a rate double that of white men.
- Incarceration: According to the Department of Justice, in 2003, over 9% of all black males, ages 26 to 29 were incarcerated. According to the Justice Policy Institute, black men in their early 30's are twice more likely to have prison records than Bachelor degrees. Finally, according to the Florida Department of Corrections, in 2004, 51.9% of Florida's prison population consisted of African-American males.
- Education: According to the American Council on Education, over the past decade, the high school graduation rate for black men has fallen 43%. The Department of Education reported in January 2005 that while the majority of dropouts in 2003-04 were white students, dropout rates were highest among Black and Hispanic students. Of the 25,587 dropouts reported for grades 9-12 in the 2003-04 school year, 7,801 (30.5 percent) were Black. The dropout rate for Blacks fell from 5.5 percent in 1999-00 to 3.6 percent in 2003-04. Dropout rates also vary by gender group, with males having a higher percentage of dropouts than females.

The Centers for Disease Control and Prevention cite homicide as the leading cause of death for black males between the ages of 15 and 34, with 4,412 such victims in 2000 alone. From 1976 to 2000, 195,757 African-American males have been victims of homicide according to the Federal Bureau of Investigation. That figure does not include the 56,776 murdered African-American females, which brings the total black homicide count over the past 27 years to 252,533. According to the Bureau of Justice Statistics, 94% of black homicide victims were killed by other blacks. The white homicide toll in the same time frame totals 275,529, which means the Black rate is more than six times higher.

Highlights of the Equality Index Findings in Five Areas include:

On March 24, 2003, as part of "The State of Black America 2004: The Complexity of Black Progress," the National Urban League released an "Equality Index," a statistical measurement of the disparities that exist between blacks and whites in economics, health, education, social justice, and civic engagement.

- Economics - Black economic status measures 56% of white counterparts
- Health - Blacks' health status measures 78% of whites
- Education - Total educational performance is 76% as compared to whites
- Social Justice - When it comes to equality under the law, blacks' status is 73%
- Civic Engagement - Blacks out measure whites in the area of civic engagement (voter registration, volunteerism, government service).
    - **Democratic Process**: The registered voter index shows a slightly higher percentage of whites registered to vote than blacks.
    - **Volunteerism**: Volunteerism includes both community volunteerism and military volunteerism. Military volunteerism indicates that a substantially higher percentage of blacks volunteer in the military. The unionism index shows a higher percentage of blacks in unions than whites. Union representation index shows that blacks are more concentrated in union jobs than whites.
    - **Government Employment**: Federal Government Employment index shows a greater percentage of blacks employed by federal government than whites, almost twice the rate. The index shows significantly more blacks concentrated in state and local government jobs than whites.

According to the Centers for Disease Control and Prevention, poverty rarely kills directly. Few people drop dead in the streets from hunger or exposure to the elements. Poverty does produce a range of physical and psychological stresses, and some reactions to these stresses are expressed in behaviors that destroy life. Members of the victim group may contribute to their own victimization through adaptations to bleak life conditions that include violence directed at self or others (e.g., suicide and homicide) as well as self-destructive lifestyles (notably addiction to drugs and alcohol).

The Florida Consortium of Urban Leagues conducts a Statewide Black-on-Black Crime Prevention Program to combat crime in the African-American community. This program is funded by the Florida Legislature through the Florida Department of Legal Affairs. The Pinellas County Urban League is the lead affiliate for this campaign, which also includes the Urban League affiliates in Ft. Lauderdale, Jacksonville, Miami, Orlando, Tallahassee, Tampa, and West Palm Beach.

This program is designed as a public awareness and education effort to motivate the Black community to support, promote, and participate in crime prevention programs and activities. This campaign also focuses on methods and measures of increasing public awareness and educating the Black community on the extent of crime in the Black community. Although awareness and education are necessary first steps, the elimination of crime in Black communities is the program's ultimate goal.

While each affiliate is granted flexibility in choosing the techniques and activities deemed most appropriate in addressing the particular needs of their respective communities, the Consortium as a whole works to achieve common objectives as outlined in the program's contract.

According to the bill sponsor, social issues facing African-American males are not limited to Florida. Other state legislatures have realized the social problems facing African-American males and have created commissions to remedy the problems within their own states. These commissions include:

- Ohio Commission on African-American Males
- Indiana Commission on the Social Status of Black Males
- Washington, D.C. Commission on African-American Males
- Maryland Task Force on the Education of African-American Males

Effects:

The council will consist of 19 members who will be appointed. Two members each from the House and Senate, not from the same political party, will serve on this council. The members from the House will

be appointed by the Speaker of the House of Representatives and the members from the Senate will be appointed by the Senate President. The other members appointed to this council will include the following individuals or their designees: the Secretary of the Department of Children and Family Services; the director of the Mental Health Program Office within the Department of Children and Family Services; the Secretary of the Department of Health; the Commissioner of Education; the Secretary of the Department of Corrections; the Attorney General; the Secretary of the Department of Management Services; the director of the Agency for Workforce Innovation; a businessperson of African-American origin appointed by the Governor; two persons appointed by the President of the Senate who are not members of the Legislature, one of whom must be a clinical physiologist; two persons appointed by the Speaker of the House of Representatives who are not members of the Legislature or employed by state government, one of whom must be an Africana studies professional; the deputy secretary for Medicaid in the Agency for Health Care Administration; and the Secretary of the Department of Juvenile Justice.

The council shall make a systematic study of the conditions affecting African-American men and boys, including, but not limited to, homicide rates, arrest and incarceration rates, poverty, violence, drug abuse, death rates, disparate annual income levels, school performance in all grade levels including postsecondary levels, and health issues.

Once this study has been conducted, the council shall propose measures to alleviate and correct the underlying causes of the conditions described above. These measures may consist of changes to the law or systematic changes that can be implemented without legislative action. The council may study other topics suggested by the Legislature or as directed by the chair of the council. The council shall receive suggestions or comments pertinent to the applicable issues from members of the Legislature, governmental agencies, public and private organizations, and private citizens. The council shall meet quarterly and at the call of the chair or as determined by a majority of council members.

The Office of the Attorney General shall provide staff and administrative support to the council. The Office of the Attorney General submitted a fiscal impact of $182,751 for three FTE positions to provide administrative support to the council and to cover any necessary travel and per diem costs for council members conducting council business.

The council shall issue its first annual report by December 15, 2007, and by December 15 of each following year. The report will outline the findings, conclusions, and recommendations of the council. These findings shall be submitted to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairpersons of the standing committees of jurisdiction in each chamber.

This council shall expire July 1, 2012, unless reenacted by the Legislature. This act shall take effect July 1, 2006.

C. SECTION DIRECTORY:

Section 1. Creates the Council on the Social Status of African-American Men and Boys.

Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

	FY 2005-06
Office of the Attorney General	
Recurring Budget:	
3 FTE Positions	
Salaries and Benefits	$123,194
Expenses	52,478
OCO	5,900
HR:	1,179
Total:	**$182,751**
Non-Recurring Budget:	
Expenses	$9,427
OCO	5,900
Total:	**$15,377**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditures of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not provide rulemaking authority to the Attorney General's Office.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On October 19, 2005, the Future of Florida's Families Committee adopted a strike everything amendment and reported the bill favorably with a committee substitute. The committee substitute contains two technical changes to clarify the intent and a third change to address reimbursement for per diem and travel expenses for all council members.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Future of Florida's Families Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the social status of African-American men and boys; creating the Council on the Social Status of African-American Men and Boys; providing for the appointment and qualification of members; providing for the appointment of members to fill vacant positions; requiring the council to make a systematic study of conditions affecting African-American men and boys; requiring the Office of the Attorney General to provide administrative support; requiring the council to submit an annual report to the Governor and Legislature; providing for reimbursement for per diem and travel expenses; requiring the Attorney General to organize the initial meeting of the council; providing for the expiration of the council; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Council on the Social Status of African-American Men and Boys.--

(1) The Council on the Social Status of African-American Men and Boys is established within the Department of Legal Affairs and shall consist of 19 members appointed as follows:

(a) Two members of the Senate who are not members of the same political party, appointed by the President of the Senate with the advice of the Minority Leader of the Senate.

(b) Two members of the House of Representatives who are not members of the same political party, appointed by the Speaker of the House of Representatives with the advice of the Minority Leader of the House of Representatives.

(c) The Secretary of Children and Family Services or his or her designee.

(d) The director of the Mental Health Program Office within the Department of Children and Family Services or his or her designee.

(e) The Secretary of Health or his or her designee.

(f) The Commissioner of Education or his or her designee.

(g) The Secretary of Corrections or his or her designee.

(h) The Attorney General or his or her designee.

(i) The Secretary of Management Services or his or her designee.

(j) The director of the Agency for Workforce Innovation or his or her designee.

(k) A businessperson of African-American origin appointed by the Governor.

(l) Two persons appointed by the President of the Senate who are not members of the Legislature or employed by state government. One of the appointees must be a clinical physiologist.

(m) Two persons appointed by the Speaker of the House of Representatives who are not members of the Legislature or employed by state government. One of the appointees must be an Africana studies professional.

(n) The deputy secretary for Medicaid in the Agency for Health Care Administration or his or her designee.

(o) The Secretary of Juvenile Justice or his or her designee.

(2) A member of the council may be removed at any time by the member's appointing authority who shall fill the vacancy on the council.

(3)(a) At the first meeting of the council each year, the members shall elect a chair and a vice chair.

(b) A vacancy in the office of chair or vice chair shall be filled by vote of the remaining members.

(4)(a) The council shall make a systematic study of the conditions affecting African-American men and boys, including, but not limited to, homicide rates, arrest and incarceration rates, poverty, violence, drug abuse, death rates, disparate annual income levels, school performance in all grade levels including postsecondary levels, and health issues.

(b) The council shall propose measures to alleviate and correct the underlying causes of the conditions described in paragraph (a). These measures may consist of changes to the law

or systematic changes that can be implemented without legislative action.

(c) The council may study other topics suggested by the Legislature or as directed by the chair of the council.

(d) The council shall receive suggestions or comments pertinent to the applicable issues from members of the Legislature, governmental agencies, public and private organizations, and private citizens.

(5) The Office of the Attorney General shall provide staff and administrative support to the council.

(6) The council shall meet quarterly and at other times at the call of the chair or as determined by a majority of council members and approved by the Attorney General.

(7) Ten of the members of the council shall constitute a quorum, and an affirmative vote of a majority of the members present is required for final action.

(8) The council shall issue its first annual report by December 15, 2007, and by December 15 each following year, stating the findings, conclusions, and recommendations of the council. The council shall submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairpersons of the standing committees of jurisdiction in each chamber.

(9) Members of the council shall serve without compensation. Members are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061, Florida Statutes. State officers and employees shall be reimbursed from the budget

of the agency through which they serve. Other members may be reimbursed by the Department of Legal Affairs.

(10) Notwithstanding subsection (6), the Attorney General shall:

(a) Within 60 days after the effective date of this act, fix a date for the initial meeting of the council.

(b) Notify each member of the council of the time, date, and place where the initial meeting will be held.

(c) Make any other arrangements concerning the initial meeting of the council.

(d) Serve as the presiding officer at the initial meeting of the council until a chair is elected.

(11) This section expires July 1, 2012, unless reenacted by the Legislature.

Section 2. This act shall take effect July 1, 2006.

Strike all Amendment to HB 21 CS by Rep. Peterman

- The amendment changes the name of the Council on the Social Status of African-American Men and Boys to the Council on the Social Status of Black Men and Boys.

- Council members are appointed to 4-year terms, except the initial appointments are for staggered terms (9 members appointed to 2 year terms and 10 members appointed to 4 year terms). Eleven members shall constitute a quorum.

- The initial report of the council shall include the findings of an investigation into factors causing black-on-black crime.

- Council meetings are required to be public and all records are subject to the public records requirements of law.

- All council members must file a disclosure of financial interests pursuant to law.

- The effective date is changed from July 1, 2006 to January 1, 2007.

- Bill is conformed to CS/SB 436.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1

Bill No. **HB 21 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health and Families Council

Representative(s) Peterman offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Council on the Social Status of Black Men and Boys.--

(1) The Council on the Social Status of Black Men and Boys is established within the Department of Legal Affairs and shall consist of 19 members appointed as follows:

(a) Two members of the Senate who are not members of the same political party, appointed by the President of the Senate with the advice of the Minority Leader of the Senate.

(b) Two members of the House of Representatives who are not members of the same political party, appointed by the Speaker of the House of Representatives with the advice of the Minority Leader of the House of Representatives.

(c) The Secretary of Children and Family Services or his or her designee.

(d) The director of the Mental Health Program Office within the Department of Children and Family Services or his or her designee.

(e) The Secretary of Health or his or her designee.

(f) The Commissioner of Education or his or her designee.

(g) The Secretary of Corrections or his or her designee.

(h) The Attorney General or his or her designee.

(i) The Secretary of Management Services or his or her designee.

(j) The director of the Agency for Workforce Innovation or his or her designee.

(k) A businessperson of black origin appointed by the Governor.

(l) Two persons appointed by the President of the Senate who are not members of the Legislature or employed by state government. One of the appointees must be a clinical psychologist.

(m) Two persons appointed by the Speaker of the House of Representatives who are not members of the Legislature or employed by state government. One of the appointees must be an Africana studies professional.

(n) The deputy secretary for Medicaid in the Agency for Health Care Administration or his or her designee.

(o) The Secretary of Juvenile Justice or his or her designee.

(2) Each member of the council shall be appointed to a 4 year term; however, for the purpose of providing staggered terms, of the initial appointments, 9 members shall be appointed to 2 year terms and 10 members shall be appointed to 4 year terms. A member of the council may be removed at any time by the

member's appointing authority who shall fill the vacancy on the council.

(3)(a) At the first meeting of the council each year, the members shall elect a chair and a vice chair.

(b) A vacancy in the office of chair or vice chair shall be filled by vote of the remaining members.

(4)(a) The council shall make a systematic study of the conditions affecting black men and boys, including, but not limited to, homicide rates, arrest and incarceration rates, poverty, violence, drug abuse, death rates, disparate annual income levels, school performance in all grade levels including postsecondary levels, and health issues.

(b) The council shall propose measures to alleviate and correct the underlying causes of the conditions described in paragraph (a). These measures may consist of changes to the law or systematic changes that can be implemented without legislative action.

(c) The council may study other topics suggested by the Legislature or as directed by the chair of the council.

(d) The council shall receive suggestions or comments pertinent to the applicable issues from members of the Legislature, governmental agencies, public and private organizations, and private citizens.

(5) The Office of the Attorney General shall provide staff and administrative support to the council.

(6) The council shall meet quarterly and at other times at the call of the chair or as determined by a majority of council members and approved by the Attorney General.

(7) Eleven of the members of the council shall constitute a quorum, and an affirmative vote of a majority of the members present is required for final action.

(8)(a) The council shall issue its first annual report by December 15, 2007, and by December 15 each following year, stating the findings, conclusions, and recommendations of the council. The council shall submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairpersons of the standing committees of jurisdiction in each chamber.

(b) The initial report must include the findings of an investigation into factors causing black-on-black crime from the perspective of public health related to mental health, other health issues, cultural disconnection, and cultural identity trauma.

(9) Members of the council shall serve without compensation. Members are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061, Florida Statutes. State officers and employees shall be reimbursed from the budget of the agency through which they serve. Other members may be reimbursed by the Department of Legal Affairs.

(10) The council and any subcommittees it forms shall be subject to the provisions of chapter 119, Florida Statutes, related to public records, and the provisions of chapter 286, Florida Statutes, related to public meetings.

(11) Each member of the council who is not otherwise required to file a financial disclosure statement pursuant to Section 8, Article II of the State Constitution or s. 112.3144, Florida Statutes, must file a disclosure of financial interests pursuant to s. 112.3145, Florida Statutes.

(12) Notwithstanding subsection (6), the Attorney General shall:

(a) Within 60 days after the effective date of this act, fix a date for the initial meeting of the council.

Amendment No. 1

(b) Notify each member of the council of the time, date, and place where the initial meeting will be held.

(c) Make any other arrangements concerning the initial meeting of the council.

(d) Serve as the presiding officer at the initial meeting of the council until a chair is elected.

(11) This section expires July 1, 2012, unless reenacted by the Legislature.

Section 2. This act shall take effect January 1, 2007.

========== T I T L E A M E N D M E N T ==========

Remove the entire title and insert:

A bill to be entitled

An act relating to the social status of black men and boys; creating the Council on the Social Status of Black Men and Boys; providing for the appointment and qualification of members; providing for the appointment of members to fill vacant positions; requiring the council to make a systematic study of conditions affecting black men and boys; requiring the Office of the Attorney General to provide administrative support; requiring the council to submit an annual report to the Governor and Legislature; providing for reimbursement for per diem and travel expenses; requiring the Attorney General to organize the initial meeting of the council; providing for the expiration of the council; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 67 Automated External Defibrillator Devices
SPONSOR(S): Sobel
TIED BILLS: **IDEN./SIM. BILLS:** SB 252

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	9 Y, 0 N	Ciccone	Brown-Barrios
2) Governmental Operations Committee	4 Y, 0 N	Brazzell/Mitchell	Williamson
3) Health Care Appropriations Committee	12 Y, 0 N	Money	Massengale
4) Health & Families Council		Ciccone	Moore
5)			

SUMMARY ANALYSIS

House Bill 67 permits the granting of funds from the Emergency Medical Services Trust Fund through the Emergency Medical Services Grant Program to certain youth athletic organizations to expand the use of automatic external defibrillators in the community. The bill amends the Emergency Medical Services Grant Program, under which some local governments receive funding. Greater competition may lead to some local governments not being awarded funds that they might have otherwise received if competition had been less.

The bill also requires the Department of Health to implement an educational campaign to inform persons who acquire an automated external defibrillator device about liability immunity provided under current law. Because there is no requirement in the bill as to how the educational campaign should be implemented, the department may post the information on the department's website. Therefore, no significant state fiscal impact is expected.

The effective date of this bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides Limited Government – HB 67 expands the permissible uses for funds allocated to counties from the Emergency Medical Services Trust Fund.

B. EFFECT OF PROPOSED CHANGES:

Background

Section 401.104, Florida Statutes, establishes the legislative intent for Florida Emergency Medical Services Grant Act.

> [E]mergency medical services are essential to the health and well-being of all citizens and that private and public expenditures for adequate emergency medical services represent a constructive and essential investment in the future of the state and our democratic society. A major impediment to the provision of adequate and economic emergency medical services to all citizens is the inability of governmental and private agencies within a service area to respond cooperatively to finance the systematic provision of such services.

The Emergency Medical Services Grant Program was established to address this impediment.

The Department of Health (DOH) is authorized to dispense grant monies from the Emergency Medical Services Trust Fund according to the distribution formulas provided in section 401.113(a) and (b), Florida Statutes, as follows:

- Forty-five percent of the monies collected by the DOH must be divided among the counties according to the proportion of the combined amount deposited in the trust fund from the county. An individual board of county commissioners may distribute these funds to emergency medical service organizations within the county, as it deems appropriate [s. 401.113(a)].
- Forty percent of the monies collected by DOH are for making matching grants to local agencies, municipalities, and emergency medical services organizations for the purpose of conducting research, increasing existing levels of emergency medical services evaluation, community education, injury prevention programs, and training in cardiopulmonary resuscitation and other lifesaving and first aid techniques [s. 401.113(b)]. These funds are awarded based on a formal review process involving local emergency medical services personnel from across the state.

During Fiscal Year 2004-2005, 66 of the 67 counties applied to receive county grant funds totaling $5.2 million under section 401.113(a), Florida Statutes, including $236,314 carried over from the previous fiscal year. During Fiscal Year 2004-2005, a total of 151 applications for matching grants were received; 63 were funded. The funds awarded totaled $4.42 million.

According to a number of articles in *The Physician and Sportsmedicine,* there is increased interest to provide access to automatic external defibrillators at national and local sporting events. Specifically, an article written by Dr. Aaron Rubin, *The Physician and Sportsmedicine*, Vol 28 No.3, March 2000, reads:

> Although sudden cardiac death is rare in sports, having an automated external defibrillator (AED) available facilitates early defibrillation and increases the chance of survival for an athlete in cardiac arrest. In sudden cardiac arrest, the most frequent initial rhythm is ventricular fibrillation (VF). The only effective treatment for VF is electrical defibrillation and the probability of success declines rapidly over time. Chances of resuscitation decrease 7 percent to 10 percent each minute.

An earlier article in the same publication: "Automatic External Defibrillators in the Sports Arena: The Right Place, The Right Time," Vol. 26 No. 12, December 1998, supports the benefits of having an AED accessible to athletes during sporting events. "In large sports settings, AEDs can supplement standby EMS services. At sports events in small towns or venues, the AED may be the only means available to effect early defibrillation."

Proposed Changes

The bill expands the list of eligible participants in the Emergency Medical Services Grant Program to include youth athletic organizations who work in conjunction with local emergency medical services organizations. The bill permits youth athletic organizations to apply for grants for the purpose of expanding the use of automatic external defibrillators in the community.

The bill directs the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under section 768.1325, Florida Statutes, for harm resulting from the use or attempted use of the device, does not apply if he or she fails to properly maintain and test the device or provide appropriate training in the use of the device.

C. SECTION DIRECTORY:

Section 1. Adds section 401.107(6) and (7), Florida Statutes, providing definitions of "youth athletic organization" and "automatic external defibrillator."

Section 2. Amends section 401.111, Florida Statutes, to include youth athletic organizations as eligible participants in the emergency medical services grant program.

Section 3. Amends section 401.113(a) and (b), Florida Statutes, to include youth athletic organizations as eligible participants in the emergency medical services grant program.

Section 4. Creates an unnumbered section of law requiring the Department of Health to implement an educational campaign regarding liability immunity during use of automated external defibrillator devices.

Section 5. Provides for an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None. This bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

   The bill does not require what medium should be used for the educational campaign. According to the DOH, an insignificant fiscal impact will be incurred if the department uses the department's website to provide the information regarding equipment maintenance, testing and user training.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill expands the potential number of participants, but does not expand the funding available. Thus, some youth athletic organizations may receive grant funds to purchase automatic external defibrillators. It is undetermined how many such organizations would receive grant monies. However, greater competition may lead to some private emergency medical services organizations not being awarded funds that they might have otherwise received if competition had been less. The number of such organizations is indeterminate.

D. FISCAL COMMENTS:

Revenues for the Emergency Medical Services Grant Program are generated through traffic fines and civil penalties transferred from the Department of Highway Safety and Motor Vehicles. The bill does not expand the potential receipt of these revenues.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to spend funds or to take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rulemaking authority to implement the requirements of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

None.

A bill to be entitled

An act relating to automated external defibrillator devices; amending s. 401.107, F.S.; defining the terms "youth athletic organization" and "automated external defibrillator device"; amending s. 401.111, F.S.; providing for grants to youth athletic organizations for automated external defibrillator devices; amending s. 401.113, F.S.; providing for disbursement of funds from the Emergency Medical Services Trust Fund; requiring the Department of Health to implement an educational campaign to inform the public about the lack of immunity from liability regarding the use of automated external defibrillator devices under certain conditions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (6) and (7) are added to section 401.107, Florida Statutes, to read:

401.107 Definitions.--As used in this part, the term:

(6) "Youth athletic organization" means a private not-for-profit organization that promotes and provides organized athletic activities to youth.

(7) "Automated external defibrillator device" means a device as defined in s. 768.1325(2)(b).

Section 2. Section 401.111, Florida Statutes, is amended to read:

401.111 Emergency medical services grant program;

authority.--The department is hereby authorized to make grants to local agencies, ~~and~~ emergency medical services organizations, and youth athletic organizations in accordance with any agreement entered into pursuant to this part. These grants shall be designed to assist local ~~said~~ agencies and emergency medical services organizations in providing emergency medical services, including emergency medical dispatch, and to assist youth athletic organizations that work in conjunction with local emergency medical services organizations to expand the use of automated external defibrillator devices in the community. The cost of administering this program shall be paid by the department from funds appropriated to it.

Section 3. Paragraphs (a) and (b) of subsection (2) of section 401.113, Florida Statutes, are amended to read:

401.113 Department; powers and duties.--

(2) The department shall annually dispense funds contained in the Emergency Medical Services Trust Fund as follows:

(a) Forty-five percent of such moneys must be divided among the counties according to the proportion of the combined amount deposited in the trust fund from the county. These funds may not be used to match grant funds as identified in paragraph (b). An individual board of county commissioners may distribute these funds to emergency medical services ~~service~~ organizations and youth athletic organizations within the county, as it deems appropriate.

(b) Forty percent of such moneys must be used by the department for making matching grants to local agencies, municipalities, ~~and~~ emergency medical services organizations,

and youth athletic organizations for the purpose of conducting research, increasing existing levels of emergency medical services, evaluation, community education, injury-prevention programs, and training in cardiopulmonary resuscitation and other lifesaving and first aid techniques.

1. At least 90 percent of these moneys must be made available on a cash matching basis. A grant made under this subparagraph must be contingent upon the recipient providing a cash sum equal to 25 percent of the total department-approved grant amount.

2. No more than 10 percent of these moneys must be made available to rural emergency medical services, and notwithstanding the restrictions specified in subsection (1), these moneys may be used for improvement, expansion, or continuation of services provided. A grant made under this subparagraph must be contingent upon the recipient providing a cash sum equal to no more than 10 percent of the total department-approved grant amount.

The department shall develop procedures and standards for grant disbursement under this paragraph based on the need for emergency medical services, the requirements of the population to be served, and the objectives of the state emergency medical services plan.

Section 4. The Department of Health shall implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under s. 768.1325, Florida Statutes, for harm

resulting from the use or attempted use of the device, does not apply if he or she fails to:

(1) Properly maintain and test the device; or

(2) Provide appropriate training in the use of the device to his or her employee or agent when the employee or agent was the person who used the device on the victim, except as provided in s. 768.1325, Florida Statutes.

Section 5. This act shall take effect July 1, 2006.

Amendment to HB 67 by Rep. Sobel

In directing the Department of Health to mount an educational campaign about the immunity provided for in section 768.1325, F. S., the present language of the bill attempts to "summarize" the terms of the immunity, but it does so in a way that is, at best, incomplete. Rather than try to summarize the terms of the immunity, the amendment eliminates any possible confusion by simply referencing that statute by section.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (for drafter's use only)

Bill No. **67**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

Council/Committee hearing bill: Health & Families

Representative(s) Sobel offered the following:

Amendment

Remove line(s) 83-91 and insert:

automated external defibrillator device of the scope and limitations of the immunity from liability provided under s. 768.1325, Florida Statutes.

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 93 CS Automated External Defibrillators
SPONSOR(S): Henriquez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	9 Y, 0 N, w/CS	Ciccone	Brown-Barrios
2) Criminal Justice Committee	8 Y, 0 N, w/CS	Ferguson	Kramer
3) Health Care Appropriations Committee	12 Y, 0 N	Money	Massengale
4) Health & Families Council		Ciccone	Moore
5)			

SUMMARY ANALYSIS

An Automatic External Defibrillator (AED) is a small, lightweight device used to assess a person's heart rhythm, and, if necessary, administer an electric shock to restore a normal rhythm in victims of sudden cardiac arrest. AEDs are designed to be used by people without medical backgrounds, such as police, firefighters, flight attendants, security guards, and lay rescuers. House Bill 93 CS defines the term *automated external defibrillator* as referenced in section 768.1325(2) (b), Florida Statutes, and also defines the term *defibrillation*.

The bill also creates a misdemeanor offense for tampering with or rendering an AED inoperable; however, this section will not apply to the owner of an AED or the owner's agent.

The bill requires the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that the liability immunity under section 768.1325, Florida Statutes, is contingent upon proper equipment maintenance, testing and user training.

Because there is no requirement in the bill as to how the educational campaign should be implemented, the department may post the information on the department's website. Therefore, no significant state fiscal impact is expected.

The effective date of this bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility – The bill creates criminal penalties for intentional or willful conduct.

B. EFFECT OF PROPOSED CHANGES:

Cardiac Arrest

The American Heart Association (AHA) describes a cardiac arrest as:

> [t]he sudden, abrupt loss of heart function. It is also called sudden cardiac arrest or unexpected cardiac arrest. Sudden death (also called sudden cardiac death[1]) occurs within minutes after symptoms appear. The most common underlying reason for patients to die suddenly from cardiac arrest is coronary heart disease. Most cardiac arrests that lead to sudden death occur when the electrical impulses in the diseased heart become rapid (ventricular tachycardia) or chaotic (ventricular fibrillation) or both. This irregular heart rhythm (arrhythmia) causes the heart to suddenly stop beating.

According to the AHA, brain death and permanent death start to occur within 4 to 6 minutes after someone experiences cardiac arrest. Cardiac arrest can be reversed if it is treated within a few minutes with an electric shock to the heart to restore a normal heartbeat—a process called defibrillation. The AHA states that a victim's chances of survival are reduced by 7 to 10 percent with every passing minute without defibrillation, and few attempts at resuscitation succeed after 10 minutes.

An Automated External Defibrillator (AED) is an electronic device that can shock a person's heart back into rhythm when he or she is having a cardiac arrest. The AHA estimates that more than 95 percent of cardiac arrest victims die before reaching the hospital. In cases where defibrillation is provided within 5 to 7 minutes, the survival rate from sudden cardiac arrest can be up to 49 percent.

Section 401.2915, Florida Statutes, provides the minimum requirements for an individual who intends to use an AED in cases of cardiac arrest, as follows:

- A person must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator;
- A person or entity in possession of an automated external defibrillator is encouraged to register with the local emergency medical services medical director the existence and location of the automated external defibrillator; and,
- A person who uses an automated external defibrillator is required to activate the emergency medical services system as soon as possible upon use of the automated external defibrillator.

1990 Legislation

In 1990, based on the development of AED technology and in an effort to reduce the death rate associated with sudden cardiac arrest, the Legislature enacted section 401.291, Florida Statutes. This law broadened the list of persons authorized to use an AED to include "first responders." First responders included police officers, firefighters and citizens who are trained as part of locally

[1] Heart Rhythm Society . *See* http://www.hrspatients.org/patients/heart_disorders/cardiac_arrest/

coordinated emergency medical service response teams. At that time, to use an AED, a first responder had to meet specific training requirements, including;

- Certification in CPR.
  Or—
- Successful completion of an eight hour basic first aid course that included CPR training.
- Demonstrated proficiency in the use of an automatic or semiautomatic defibrillator.
- Successful completion of at least six hours of training, in at least two sessions, in the use of an AED.

At the time, the creation of section 401.291, Florida Statutes, was intended to increase the availability of automatic external defibrillators, and thereby, reduce the death rate from sudden cardiac arrest in Florida. It is undocumented as to whether the intended effect was ever achieved; however, the law was repealed in 1997.

Deregulating AED

Chapter 97-34, Laws of Florida, repealed section 401.291, Florida Statutes, thereby deregulating the use of an AED. The bill created section 401.2915, Florida Statutes. (see above).

Tort Liability

Section 768.1325, Florida Statutes, the Cardiac Arrest Survival Act, provides immunity from liability for a person who uses or attempts to use an automated external defibrillator device in a perceived medical emergency. Under section 768.1325(2) (b), Florida Statutes, "automated external defibrillation" device is defined as a defibrillator device that:

- Is commercially distributed in accordance with the Federal Food, Drug, and Cosmetic Act.
- Is capable of recognizing the presence or absence of ventricular fibrillation, and is capable of determining without intervention by the user of the device whether defibrillation should be performed.
- Upon determining that defibrillation should be performed, is able to deliver an electrical shock to an individual.

Section 768.1325 (3), Florida Statutes, provides exceptions in that any person who uses or attempts to use an automated external defibrillator device on a victim of a perceived medical emergency is immune from civil liability. In addition, any person who acquired the device for a community organization is immune from civil liability if the harm was not a result of the failure of such acquirer of the device to:

- Notify the local emergency medical services medical director of the most recent placement of the device within a reasonable period of time after the device was placed.
- Properly maintain and test the device.
- Provide appropriate training in the use of the device to an employee or agent of the acquirer when the employee or agent was the person who used the device on the victim, except that such requirement of training does not apply if:

    1. The employee or agent was not an employee or agent who would have been reasonably expected to use the device.

2. The period of time elapsing between the engagement of the person as an employee or agent and the occurrence of the harm, or between the acquisition of the device and occurrence of the harm in any case in which the device was acquired after engagement of the employee or agent, was not a reasonably sufficient period in which to provide the training.

Effect of Bill

House Bill 93 CS amends section 401.2915, Florida Statutes, to define the term automated external defibrillator as a lifesaving device that:

- Is commercially distributed as a defibrillation device in accordance with the Federal Food, Drug, and Cosmetic Act.
- Is capable of recognizing the presence or absence of ventricular fibrillation and is capable of determining, without intervention by the use of the device, if defibrillation should be performed.
- Is capable of delivering an electrical shock to an individual, upon determining that defibrillation should be performed.

This definition conforms to the definition in section 768.1325(2) (b), Florida Statutes.

The bill also defines defibrillation as the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm.

The bill creates a first degree misdemeanor for any person who intentionally or willfully:

a) Tampers with or otherwise renders an automated external defibrillator inoperative except during such time as the automated external defibrillator is being serviced, tested, repaired, or recharged, except pursuant to court order.

b) Obliterates the serial number on an automated external defibrillator for purposes of falsifying service records.

Paragraph (a) does not apply to the owner of the automated external defibrillator or the owner's agent. A first degree misdemeanor is punishable by up to one year in jail and a fine of up to $1,000.

The bill directs the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under section 768.1325, Florida Statutes, for harm resulting from the use or attempted use of the device, does not apply if he or she fails to properly maintain and test the device or provide appropriate training in the use of the device.

C. SECTION DIRECTORY:

Section 1. Amends section 401.2915, Florida Statutes, to define terms and provide criminal penalties.

Section 2. Creates an unnumbered section of law requiring the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that the liability immunity under section 768.1325, Florida Statutes, is contingent upon proper equipment maintenance, testing and user training.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None. This bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

The bill does not require the medium that should be used for the educational campaign. According to the DOH, an insignificant fiscal impact will be incurred if the department uses the department's website to provide the information regarding equipment maintenance, testing and user training.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

The bill creates a misdemeanor fine of up to $1,000; however, the revenue impact is indeterminate at this time.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

See above.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to spend funds or to take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rulemaking authority to implement the requirements of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On November 9, 2005, the House Health Care General Committee passed House Bill 93 with one amendment, which referenced the definition of an Automatic External Defibrillator (AED) currently in s. 768.1325(2)(b) F.S.

The House Health Care General Committee passed House Bill 93 with this amendment as House Bill 93 with Committee Substitute.

On January 11, 2006, the Criminal Justice Committee passed House Bill 93 with two amendments. The bill made it a misdemeanor for any person to render an AED inoperable. The first amendment provided that this does not apply to the owner of the AED or the owner's agent. The second amendment deleted the provision authorizing local governments to adopt an ordinance to license, permit, or inspect AEDs and providing enforcement of such local ordinances.

This analysis reflects the bill as amended.

CHAMBER ACTION

The Criminal Justice Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to automated external defibrillators; amending s. 401.2915, F.S.; revising legislative intent with respect to the use of an automated external defibrillator; defining the terms "automated external defibrillator" and "defibrillation"; providing that it is a first degree misdemeanor for a person to commit certain acts involving the misuse of an automated external defibrillator; providing penalties and an exception; requiring the Department of Health to implement an educational campaign to inform the public about the lack of immunity from liability regarding the use of automated external defibrillators under certain conditions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 401.2915, Florida Statutes, is amended to read:

401.2915 Automated external defibrillators.--It is the intent of the Legislature that an automated external defibrillator may be used by any person for the purpose of saving the life of another person in cardiac arrest. In order to achieve that goal, the Legislature intends to encourage training in lifesaving first aid and set standards for and encourage the use of automated external defibrillators.

(1) As used in this section, the term:

(a) "Automated external defibrillator" means a device as defined in s. 768.1325(2)(b).

(b) "Defibrillation" means the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm.

(2) In order to ensure public health and safety:

(a) ~~(1)~~ All persons who use an automated external defibrillator must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator.

(b) ~~(2)~~ Any person or entity in possession of an automated external defibrillator is encouraged to register with the local emergency medical services medical director the existence and location of the automated external defibrillator.

(c) ~~(3)~~ Any person who uses an automated external defibrillator shall activate the emergency medical services system as soon as possible upon use of the automated external defibrillator.

(3) Any person who intentionally or willfully:

(a) Tampers with or otherwise renders an automated external defibrillator inoperative, except during such time as the automated external defibrillator is being serviced, tested, repaired, recharged, or inspected or except pursuant to court order; or

(b) Obliterates the serial number on an automated external defibrillator for purposes of falsifying service records,

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Paragraph (a) does not apply to the owner of the automated external defibrillator or the owner's agent.

(4) Each local and state law enforcement vehicle may carry an automated external defibrillator.

Section 2. The Department of Health shall implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under s. 768.1325, Florida Statutes, for harm resulting from the use or attempted use of the device, does not apply if he or she fails to:

(1) Properly maintain and test the device; or

(2) Provide appropriate training in the use of the device to his or her employee or agent when the employee or agent was the person who used the device on the victim, except as provided in s. 768.1325, Florida Statutes.

Section 3. This act shall take effect July 1, 2006.

Amendments to HB 93 CS by Rep. Henriquez

Amendment #1:

Most companies avoid any connotation that a person they authorize to perform a particular act is their "agent," since this label is loaded with far-reaching legal implications. Rather, most companies view a person they authorize to perform a specific task as their "authorized representative" for that purpose, but not as their "agent." Thus, a person who might render an AED temporarily inoperative as the "authorized representative" of the owner might not be covered by the exemption from criminal liability contained in this part of the bill. As such, the amendment modifies the exemption from criminal liability to include an owner's "authorized representative or agent."

Amendment #2:

In directing the Department of Health to mount an educational campaign about the immunity provided for in section 768.1325, F.S., the present language of the bill attempts to "summarize" the terms of the immunity, but it does so in a way that is, at best, incomplete. Rather than try to summarize the terms of the immunity, the amendment eliminates any possible confusion by simply referencing that statute by section.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **93 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families

Representative(s) Henriquez offered the following:

Amendment

On line(s) 64, after "owner's", insert: authorized representative or

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HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2 (for drafter's use only)

Bill No. **93 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families

Representative(s) Henriquez offered the following:

Amendment (with directory and title amendments)

Remove line(s) 69-77 and insert:

automated external defibrillator device of the scope and limitations of the immunity from liability provided under s. 768.1325, Florida Statutes.

========== D I R E C T O R Y A M E N D M E N T ==========

Remove line(s) and insert:

========== T I T L E A M E N D M E N T ==========

Remove line(s) and insert:

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 111 Defibrillators in State Parks
SPONSOR(S): Anderson
TIED BILLS: **IDEN./SIM. BILLS:** SB 274

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	9 Y, 0 N	Ciccone	Brown-Barrios
2) Agriculture & Environment Appropriations Committee	9 Y, 0 N	Dixon	Dixon
3) Health & Families Council		Ciccone	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 111 creates section 258.0165, F.S., to encourage each state park to have a functioning automated external defibrillator (AED) at all times.

This bill appropriates $92,000 from the General Revenue Fund to the Division of Recreation and Parks, Department of Environmental Protection. The appropriated funds are to be used to purchase as many AEDs as possible.

The bill provides an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Over the last two fiscal years, an average of 18.2 million people visited Florida's state parks. According to the Department of Environmental Protection (DEP), there are approximately158 state parks and 12 of these already have AEDs. These AEDS were either purchased by the department or received from donors.

Section 768.13, F.S., the Good Samaritan Act, provides immunity from civil liability to any persons, including those licensed to practice medicine, who gratuitously and in good faith render emergency care or treatment either in direct response to emergency situations related to and arising out of a state of emergency which has been declared pursuant to section 252.36, F.S., or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment. Specifically as it relates to the use of an AED, section 768.1325, F.S., the Cardiac Arrest Survival Act, provides immunity from liability for a person who uses or attempts to use an AED.

Background

The American Heart Association (AHA) describes a cardiac arrest as:

> Cardiac arrest is the sudden, abrupt loss of heart function. It is also called sudden cardiac arrest or unexpected cardiac arrest. Sudden death (also called sudden cardiac death) occurs within minutes after symptoms appear. The most common underlying reason for patients to die suddenly from cardiac arrest is coronary heart disease. Most cardiac arrests that lead to sudden death occur when the electrical impulses in the diseased heart become rapid (ventricular tachycardia) or chaotic (ventricular fibrillation) or both. This irregular heart rhythm (arrhythmia) causes the heart to suddenly stop beating.

According to the AHA, brain death and permanent death start to occur within 4 to 6 minutes after someone experiences cardiac arrest. Cardiac arrest can be reversed if it is treated within a few minutes with an electric shock to the heart to restore a normal heartbeat—a process called defibrillation. The AHA states that a victim's chances of survival are reduced by 7 to 10 percent with every passing minute without defibrillation, and few attempts at resuscitation succeed after 10 minutes.

An AED is an electronic device that can shock a person's heart back into rhythm when he or she is having a cardiac arrest. The AHA estimates that more than 95 percent of cardiac arrest victims die before reaching the hospital. In cases where defibrillation is provided within 5 to 7 minutes, the survival rate from sudden cardiac arrest can be up to 49 percent.

Section 401.2915, F.S., provides the minimum requirements for an individual who intends to use an AED in cases of cardiac arrest, as follows:

- A person must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary

resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator;
- A person or entity in possession of an automated external defibrillator is encouraged to register with the local emergency medical services medical director the existence and location of the automated external defibrillator; and
- A person who uses an automated external defibrillator is required to activate the emergency medical services system as soon as possible upon use of the automated external defibrillator.

Effect of Proposed Change

The bill would:

- Encourage each state park to have a functioning AED at all times.
- Require state parks that provide an AED to ensure that employees and volunteers are properly trained in accordance with section 401.2915, F.S.
- Require the AED location to be registered with a local emergency medical services medical director.
- Provide that the Good Samaritan Act and the Cardiac Arrest Survival Act applies to AEDs used by employees and volunteers.

The bill provides that the Division of Recreation and Parks, Department of Environmental Protection, may adopt rules pursuant to section 120.536(1), F.S., and section 120.54, F.S., to implement the provisions of this section of statute.

The bill appropriates $92,000 from the General Revenue Fund to the Division of Recreation and Parks, Department of Environmental Protection, for the purpose of implementing this act. According to the American Heart Association representatives, the average cost of an AED is approximately $1,500 to $1,800. Based on that average cost, this appropriation could fund an additional 51 to 61 AEDs for state parks.

C. SECTION DIRECTORY:

Section 1. Creates s. 258.0165, F.S., regarding defibrillators in state parks.

Section 2. Appropriates $92,000 from the General Revenue Fund to the Division of Recreation and Parks, Department of Environmental Protection, for the purpose of implementing this act.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   Non-Recurring Expense:

   Department of Environmental Protection Fiscal Year 2006-07

General Revenue Fund	$92,000
Total Expense	$92,000

Note: $92,000 in FY 2006-07 is appropriated to the Division of Recreation and Parks, Department of Environmental Protection for the purchase of as many AEDs as possible.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill would benefit the successful bidder on a contract to provide AEDs to state parks.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to spend funds or take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None

B. RULE-MAKING AUTHORITY:

This bill authorizes the Division of Recreation and Parks, Department of Environmental Protection to adopt rules to implement the provisions of section 258.0165, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to defibrillators in state parks; creating s. 258.0165, F.S.; encouraging state parks to have a functioning automated external defibrillator; requiring training, maintenance, and location registration; providing immunity from liability under the Good Samaritan Act and the Cardiac Arrest Survival Act; authorizing the Division of Recreation and Parks to adopt rules; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 258.0165, Florida Statutes, is created to read:

258.0165 Defibrillators in state parks.--

(1) Each state park is encouraged to have on the premises at all times a functioning automated external defibrillator.

(2) State parks that provide automated external defibrillators shall ensure that employees and volunteers are properly trained in accordance with s. 401.2915.

(3) The location of each automated external defibrillator shall be registered with a local emergency medical services medical director.

(4) The use of automated external defibrillators by employees and volunteers shall be covered under the provisions of ss. 768.13 and 768.1325.

(5) The Division of Recreation and Parks may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this section.

Section 2. The sum of $92,000 is appropriated from the General Revenue Fund to the Division of Recreation and Parks of the Department of Environmental Protection for the purpose of implementing this act during the 2006-2007 fiscal year. The division shall arrange for the purchase of as many automated external defibrillators as may be purchased with this appropriation.

Section 3. This act shall take effect July 1, 2006.

Amendment to HB 111 by Rep. Anderson

The amendment changes the source of the appropriation from the General Revenue Fund to the State Park Trust Fund.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (for drafter's use only)

Bill No. **0111**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Anderson offered the following:

Amendment

Remove line 31 and insert:

State Park Trust Fund to the Division of Recreation and Parks of

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 127 CS Immunizations
SPONSOR(S): Hays
TIED BILLS: **IDEN./SIM. BILLS:** SB 1160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee	7 Y, 0 N, w/CS	DePalma	Walsh
2) PreK-12 Committee	10 Y, 0 N	Beagle	Mizereck
3) Health Care Appropriations Committee	11 Y, 0 N	Money	Massengale
4) Health & Families Council		DePalma	Moore
5)			

SUMMARY ANALYSIS

House Bill 127 CS requires district school boards and private school governing authorities to provide every student's parent specified information about meningococcal disease in accordance with the recommendations of the Department of Health (DOH). The bill requires DOH to adopt rules specifying the age or grade level of students to receive the information, consistent with recommendations of the Centers for Disease Control (CDC). It further requires DOH to make information about the disease available to district school boards and private school governing authorities, who shall determine the means and methods for providing this information to students' parents.

There appears to be no fiscal impact on state or local government. School districts and private school governing authorities may incur minor costs related to the provision of information about meningococcal disease to student's parents.

There is a potential cost to parents or private health insurance companies to cover the costs of the vaccine and administration of the vaccine for those parents who choose to vaccinate their children. According to DOH, the market price of the vaccine is $75–$100 per dose.

The effective date of this bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – House Bill 127 CS requires DOH to adopt rules specifying the age or grade level of students to receive information about meningococcal disease consistent with recommendations of the CDC. It requires DOH to make information about the disease available to district school boards and private school governing authorities, who shall determine the means and methods for providing this information to students' parents.

B. EFFECT OF PROPOSED CHANGES:

Meningococcal Disease and Immunization

The *meningococcus* bacterium can cause a life-threatening infection of the bloodstream, meningitis (infection of the brain and spinal cord coverings), or both. Sometimes referred to as spinal meningitis, bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disability. Death occurs in 10 to 14 percent of the 1,400-2,800 cases of meningococcal meningitis that are reported in the U.S. each year.[1] The largest incidence of the disease is in children under age 5, with a second peak in children and young adults between the ages of 15 and 24.[2]

Before the 1990s, *Haemophilus influenzae* type b (Hib) was the leading cause of bacterial meningitis. New vaccines being given to all children as part of their routine immunizations, however, have reduced the occurrence of invasive disease because of *H. influenzae*.[3]

There are five subtypes (or serogroups) of the bacterium that cause meningococcal meningitis (Serogroups A, B, C, Y, and W-135). Two vaccines are available to immunize against Serogroups A, C, Y and W-135: Menomune, licensed in 1981, and Menactra (manufactured by Sanofi Pasteur, and also known as MCV-4), licensed on January 14, 2005 for use in people 11-55 years of age.[4]

On May 26, 2005, the CDC recommended routine administration of the Menactra vaccine for all children 11-12 years old, previously unvaccinated adolescents at high school entry, and college freshmen living in dormitories

> [t]o help achieve vaccination among those at highest risk for meningococcal disease. As the vaccine supply increases, CDC hopes, within three years, to recommend routine vaccination for all adolescents beginning at 11 years of age.[5]

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[1] Morbidity and Mortality Weekly Report; *Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices*, May 27, 2005, Department of Health and Human Services Centers for Disease Control and Prevention, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5407a1.htm.
[2] *Vaccine Information Meningococcal Disease*, updated March 11, 2005, National Network for Immunization Information, available at http://www.immunizationinfo.org/vaccineInfo/vaccine_detail.cfv?id=15.
[3] *Division of Bacterial and Mycotic Disease, Disease Information, Meningococcal Disease*, Department of Health and Human Services Centers for Disease Control and Prevention, available at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm.
[4] There is no licensed vaccine for Serogroup B in the U.S. *Vaccine Information Meningococcal Disease.*
[5] Press Release: *CDC Recommends Meningococcal Vaccine for Adolescents and College Freshman*, May 26, 2005, Department of Health and Human Services Centers for Disease Control and Prevention, available at http://www.cdc.gov/od/oc/media/pressrel/r050526b.htm.

In September 2005, CDC and the U.S. Food and Drug Administration (FDA) issued an alert[6] after reports made to the Vaccine Adverse Event Reporting System (VAERS) indicated that five adolescents had developed Guillain-Barre Syndrome[7] (GBS) following administration of the Menactra vaccine. By November 2005, six Menactra recipients (all ages 17 or 18) experienced an onset of GBS 14-31 days after vaccination.[8] Although the timing of the onset of neurological symptoms (within the first month of vaccination) was alarming, it was not immediately known if there was a sound causal relationship between Menactra vaccination and GBS, as the six reported cases of GBS among approximately 2.5 million doses of Menactra distributed nationally is a rate similar to what might have been expected to occur by chance alone.[9]

The CDC and American Academy of Pediatrics (AAP) both continue to recommend Menactra administration for all 11 and 12 year olds at the pre-adolescent visit.[10]

Florida's public school vaccination schedule

In Florida, the following immunizations are required by age and school grade:[11]

Immunizations Required for Preschool Entry (age-appropriate doses as are medically indicated):
- Diphtheria-Tetanus-Pertussis Series
- Haemophilus influenzae type b (Hib)
- Hepatitis B
- Measles-Mumps-Rubella (MMR)
- Polio Series
- Varicella

Immunizations Required for Kindergarten Entry:
- Diphtheria-Tetanus-Pertussis Series
- Hepatitis B Series
- Measles-Mumps-Rubella (two doses of Measles vaccine, preferably as MMR)
- Polio Series
- Varicella

Immunizations Required for 7th Grade Entry:
- Hepatitis B Series

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[6] *FDA and CDC Issue Alert on Menactra Meningococcal Vaccine and Guillain Barre Syndrome*, September 30, 2005, U.S. Food and Drug Administration, available at http://www.fda.gov/bbs/topics/NEWS/2005/NEW01238.html.

[7] According to the American Academy of Pediatrics and the National Institute of Neurological Disorders and Stroke, GBS is a severe neurological disorder causing weakness of the body's extremities as a result of an inflammatory demyelination of peripheral nerves. This weakness can intensify rapidly, rendering certain muscles useless and, when severe, leave a patient almost totally paralyzed. Although anyone can be affected by GBS – the disease can occur at any age and both sexes are equally susceptible to onset – the incidence rate is only about one person in 100,000. Presently, there are no known cures for GBS, although several therapies (including plasma exchange and high-dose immunoglobulin therapy) are utilized to accelerate recovery. Recovery periods for patients experiencing GBS are varied and can range from a few weeks to a few years, although roughly 30 percent of patients experience residual weakness after 3 years. A small proportion of patients die, and 20 percent of hospitalized patients can have prolonged disability.

[8] *Guillain-Barre Syndrome Among Adolescents Who Received Meningococcal Conjugate Vaccine Factsheet*, November 9, 2005, U.S. Food and Drug Administration, available at http://www.fda.gov/bbs/topics/NEWS/2005/NEW01238.html.

[9] Morbidity and Mortality Weekly Report, *Guillain-Barre Syndrome Among Recipients of Menactra Meningococcal Conjugate Vaccine – United States, June-July 2005*, October 6, 2005, Department of Health and Human Services Centers for Disease Control and Prevention, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm54d1006a1.htm. Although the number of doses distributed is known, the precise number of administered doses is not.

[10] Ibid.

[11] *Vaccine Information Florida Vaccine Requirements*, National Network for Immunization Information, available at http://www.immunizationinfo.org/vaccineInfo/disease_stateinfo.cfv; *Immunization and Record Requirements*, available at http://www.doh.state.fl.us/disease_ctrl/immune/school.pdf

Second Dose of Measles Vaccine (preferably MMR vaccine)
Tetanus-Diphtheria Booster

Note: Since the Hepatitis B Series and Second Dose of Measles Vaccine were added to the kindergarten immunization schedule, students are not required to receive these vaccinations for 7th grade entry, unless they were not obtained previously.

Immunizations required for college/university students:
MR, M2 (All freshman and new enrollees in public universities)
Meningococcal (All college/university students who live in dorms, or must sign waiver)

Immunizations Required for Child Care and/or Family Day Care (up-to-date for age):
Diphtheria-Tetanus-Pertussis
Haemophilus influenzae type b
Measles-Mumps-Rubella
Polio
Varicella

While school districts and private schools are not currently required to provide information to parents regarding specific diseases or vaccinations, they regularly communicate with parents on a variety of topics including required immunizations and health screenings. All Florida postsecondary educational institutions must provide detailed information concerning the risks associated with meningococcal meningitis and its associated vaccines to every student or to the student's parent if the student is a minor. As noted above, all Florida college and university students who live in campus dormitories are required to be immunized against meningococcal disease or decline the immunization by signing a waiver.[12]

Proposed Changes

The bill requires each district school board and private school governing body to provide every student's parent with detailed information about the causes, symptoms and transmission of meningococcal disease, and about the availability, effectiveness, and contraindications associated with recommended vaccines. The information is to be provided in accordance with DOH recommendations.

The bill also requires DOH to adopt rules that specify the age or grade level of students for whom such information shall be provided. These rules are to be consistent with recommendations of the Advisory Committee on Immunization Practices (ACIP) concerning the appropriate age for vaccine administration.

The bill requires DOH to make available to school districts and private school governing authorities, information concerning the causes, symptoms, and transmission of meningococcal disease; the risks associated with the disease; and the availability, effectiveness and contraindications of its associated vaccines.

The bill also requires each school district and private school governing body shall determine the means and methods of providing this information to the student's parent.

C. SECTION DIRECTORY:

Section 1. Amends section 1003.22(10), Florida Statutes, relating to school-entry health examinations; creates new paragraph (c); requires district school board and private school governing authorities to provide every student's parent specified information about meningococcal disease in accordance with DOH recommendations; requires DOH to adopt rules consistent with recommendations of ACIP;

[12] s. 1006.69, F.S.

requires district school boards and private school governing authorities to determine means and methods for providing information to students' parent.

Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Although the bill does not require adolescent vaccination against meningococcal disease, the Department of Health reports there is a potential cost to parents or private health insurance companies to cover the costs of vaccine and administration of vaccine for those parents who choose to have adolescents vaccinated. The department estimates the market price of the vaccine to be $75-$100 per dose.

Private school governing authorities may incur minor costs related to the provision of information about meningococcal disease to students' parents. However, the bill allows the private school governing body to determine the method for providing such information, so they may select the most cost-effective method.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to spend funds or to take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

House Bill 127 CS requires the Department of Health to adopt rules specifying the age or grade level of students to receive the information regarding meningococcal disease, consistent with recommendations of the CDC.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 36-47: It is unclear whether DOH is required to adopt rules addressing the causes, symptoms, etc. of meningococcal disease and its associated vaccine, or merely to make such information available to schools independent of its rulemaking authority.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its January 11, 2006 meeting, the Committee on Elder & Long-Term Care adopted an amendment to House Bill 127. The amendment removed Section 1 of the bill, requiring assisted living facilities to implement a program to offer immunizations against influenza and pneumococcal bacteria to all residents age 65 and older, in its entirety.

The Committee favorably reported a Committee Substitute. This analysis is drafted to the Committee Substitute.

CHAMBER ACTION

The Elder & Long-Term Care Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to immunizations; amending s. 1003.22, F.S.; requiring each district school board and the governing authority of each private school to provide information to parents concerning meningococcal disease and the vaccine therefor; requiring the Department of Health to adopt rules specifying the age or grade level of students for whom such information will be provided; requiring each district school board and the governing authority of each private school to determine the means and method for the provision of information to parents concerning meningococcal disease; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) is added to subsection (10) of section 1003.22, Florida Statutes, to read:

1003.22 School-entry health examinations; immunization against communicable diseases; exemptions; duties of Department of Health.--

(10) Each district school board and the governing authority of each private school shall:

(c) Provide detailed information concerning the causes, symptoms, and transmission of meningococcal disease; the risks associated with meningococcal disease; and the availability, effectiveness, and known contraindications of any required or recommended vaccine against meningococcal disease to every student's parent, in accordance with the recommended ages of students determined by the Department of Health to be appropriate for the administration of such vaccine. The Department of Health shall adopt rules that specify the age or grade level of students for whom such information shall be provided, consistent with the recommendations of the Advisory Committee on Immunization Practices of the United States Centers for Disease Control and Prevention concerning the appropriate age for the administration of the vaccine, and shall make available information concerning the causes, symptoms, and transmission of meningococcal disease; the risks associated with meningococcal disease; and the availability, effectiveness, and known contraindications of any required or recommended vaccine against meningococcal disease to school districts and the governing authorities of each private school. Each district school board and the governing authority of each private school shall determine the means and methods for the provision of such information to students' parents.

Section 2. This act shall take effect July 1, 2006.

Strike All Amendment to HB 127 CS by Rep. Hays

The strike-all amendment to HB 127 CS transfers the legislation's provisions from chapter 1003, F.S., to chapter 1002, F.S., and:

- requires the Department of Education to develop guidelines for a parent guide to successful achievement, including parental information regarding school entry requirements and recommended immunization schedules, and other student health resource information;
- requires each school district to develop and disseminate a parent guide to successful student achievement that provides certain health information including a recommended immunizations schedule, and information regarding meningococcal disease; and
- requires the governing authority of each private school to provide certain health information including a recommended immunizations schedule, and information regarding meningococcal disease.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 127 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

Council/Committee hearing bill: Health & Families Council

Representative(s) Hays offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 2. Subsections (2) and (7) of section 1002.23, Florida Statutes, are amended to read:

1002.23 Family and School Partnership for Student Achievement Act.--

(2) To facilitate meaningful parent and family involvement, the Department of Education shall develop guidelines for a parent guide to successful student achievement which describes what parents need to know about their child's educational progress and how they can help their child to succeed in school. The guidelines shall include, but need not be limited to:

(a) Parental information regarding:

1. Requirements for their child to be promoted to the next grade, as provided for in s. 1008.25;

2. Progress of their child toward achieving state and district expectations for academic proficiency;

3. Assessment results, including report cards and progress reports; ~~and~~

4. Qualifications of their child's teachers; and

5. School entry requirements including immunizations, and the recommended immunization schedule;

(b) Services available for parents and their children, such as family literacy services; mentoring, tutorial, and other academic reinforcement programs; college planning, academic advisement, and student counseling services; and after-school programs;

(c) Opportunities for parental participation, such as parenting classes, adult education, school advisory councils, and school volunteer programs;

(d) Opportunities for parents to learn about rigorous academic programs that may be available for their child, such as honors programs, dual enrollment, advanced placement, International Baccalaureate, International General Certificate of Secondary Education (pre-AICE), Advanced International Certificate of Education, Florida Virtual High School courses, and accelerated access to postsecondary education;

(e) Educational choices, as provided for in s. 1002.20(6), and corporate income tax credit scholarships, as provided for in s. 220.187;

(f) Classroom and test accommodations available for students with disabilities; and

(g) School board rules, policies, and procedures for student promotion and retention, academic standards, student assessment, courses of study, instructional materials, and contact information for school and district offices.

(h) Resources for information on student health and other available resources for parents.

(7) Each school district shall develop and disseminate a parent guide to successful student achievement, consistent with the guidelines of the Department of Education, which addresses what parents need to know about their child's educational progress and how parents can help their child to succeed in school. The guide must:

(a) Be understandable to students and parents;

(b) Be distributed to all parents, students, and school personnel at the beginning of each school year;

(c) Be discussed at the beginning of each school year in meetings of students, parents, and teachers; and

(d) Include information concerning services, opportunities, choices, academic standards, and student assessment.

(e) Provide information on the importance of student health, immunizations and vaccinations available, including, but not limited to:

1. A recommended immunizations schedule in accordance with the United States Centers for Disease Control and Prevention recommendations.

2. Detailed information regarding the causes, symptoms and transmission of meningococcal disease; and the availability, effectiveness, known contraindications and the appropriate age for the administration of any required or recommended vaccine against meningococcal disease in accordance with the recommendations of the Advisory Committee on Immunization Practices of the United States Center for Disease Control and Prevention.

Section 2. Subsection (6) of section 1002.42, Florida Statutes, is amended to read:

1002.42 Private schools.--

(6) IMMUNIZATIONS.--The governing authority of each private school shall:

(a) Require students to present a certification of immunization in accordance with the provisions of s. 1003.22(3)-(11).

(b) Provide information on the importance of student health, immunizations and vaccinations available, including, but not limited to:

1. A recommended immunizations schedule in accordance with the United States Centers for Disease Control and Prevention recommendations.

2. Detailed information regarding the causes, symptoms and transmission of meningococcal disease; and the availability, effectiveness, known contraindications and the appropriate age for the administration of any required or recommended vaccine against meningococcal disease in accordance with the recommendations of the Advisory Committee on Immunization Practices of the United States Center for Disease Control and Prevention.

3. This act shall take effect July 1, 2006.

========== T I T L E A M E N D M E N T ==========

Remove the entire title and insert:

A bill to be entitled

An act relating to immunizations; amending s. 1002.23, F.S.; providing for the Department of Education to develop guidelines for a parent guide, including parental information regarding school entry requirements and recommended immunization schedules; providing for departmental guidelines regarding student health and other resources; specifying that each school district develop and disseminate a parent guide that provides certain health information including a recommended immunizations

schedule, and information regarding meningococcal disease; amending s. 1002.42, F.S.; requiring the governing authority of each private school to provide certain health information including a recommended immunizations schedule, and information regarding meningococcal disease; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 181 CS Administration of Medication
SPONSOR(S): Hays
TIED BILLS: **IDEN./SIM. BILLS:** SB 170

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Hamrick	Mitchell
2) Elder & Long-Term Care Committee	8 Y, 0 N	Walsh	Walsh
3) Health & Families Council		Hamrick	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 181 CS allows a direct service provider, who is not licensed to administer medication, the ability to administer or supervise the self-administration of medication by a client with a developmental disability, who resides in a facility regulated under Chapter 393, F.S.

The bill provides that a 4-hour medication training course must be satisfactorily completed and the direct service provider must be found competent to administer or supervise the self-administration of medication in a safe and sanitary manner. The bill requires that a consent form must be signed by a legal guardian or a legal representative.

The bill also changes "day programs" to "day habilitation services" to reference existing definitions within Chapter 393, F.S, and provides the Agency for Persons with Disabilities (APD) the authority to promulgate rules.

This bill does not appear to have a fiscal impact on state or local governments.

This bill will take effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard individual liberty --- Increases the options for facilities to provide care to the clients with developmental disabilities. The bill allows direct care providers who are not licensed to administer medication the ability to administer or to supervise the self-administration of medication, if they successfully complete a 4-hour training course in medication administration.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Developmental Disabilities and Chapter 393

Section 393.063, F.S., defines "developmental disability" as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

Section 393.063(12), F.S., provides a definition of a "direct service provider" or "caregiver" or "caretaker" as a person 18 years of age or older who has direct contact with individuals with developmental disabilities, or has access to a client's living areas or to a client's funds or personal property, and is not a relative of such individuals.

Chapter 393, F. S. regulates the following types of facilities:

- Comprehensive transitional education program centers
- Day habilitation facilities
- Developmental disabilities institutions
- Foster care facilities
- Group home facilities
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Residential facilities
- Residential habilitation centers

Types of Medications Administered to Persons with Developmental Disabilities

Currently, the administration of medication to persons with developmental disabilities in the comprehensive transitional educational program is performed by a nurse. In day programs and intermediate care facilities, unlicensed direct care staff may administer oral, transdermal, inhaled or topical prescription medications to persons with developmental disabilities.[1]

Training Requirements of Unlicensed Direct Care Staff

Currently, each facility, institution, or program under the purview of s. 393.506, F.S., must include in its policies and procedures a plan for training designated staff to ensure the safe handling, storage, and administration of prescription medication. These policies and procedures must be approved by APD before an unlicensed direct care staff assists with the administration of medication. The policies and procedures must include, at a minimum, the following provisions:

[1] See s. 393.506, F.S.

- An expressed and informed consent for each client;
- The director of the facility, program, or provider must maintain a copy of the written prescription, and that prescription must include the name of the medication, the dosage and administration schedule, the reason for the prescription, and the termination date; and
- Each prescribed medication must be kept in its original container and in a secure location.

The training required in s. 393.506, F.S., must be conducted by a registered nurse or a Florida-licensed medical physician or osteopathic physician.

Statutory Provisions for the Administration of Medication by Unlicensed Staff

Current law[2] provides authority, with specific guidelines, for unlicensed individuals to administer medication. Sections 400.488 and 400.4256, F.S., specify that assistance with self-administration does not include administration of rectal medications. These sections also limit the administration of medications by unlicensed care providers and prohibit the administration of medications where judgment or discretion is needed to determine the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration.

Statutory Provisions Related to Surrogate Families and Smaller Residential Settings

In smaller residential settings, properly trained persons or direct care staff may administer medications, as long as smaller residential settings function as a surrogate family. Under current law, incidental care may be provided to sick or non-institutionalized persons, as long as the care is performed by friends or members of the family, domestic servants, or a surrogate family.[3] This provision provides an exemption to the Nurse Practice Act, which allows an unlicensed caregiver to provide care to a surrogate family member without fear of prosecution for practicing nursing without a license.

In day programs, the director of a facility or program must designate in writing that an unlicensed direct care services staff is eligible to be trained in how to assist in the administration of medication or to administer medication directly.[4]

In an intermediate care facility, the director of a facility or program for the developmentally disabled may designate unlicensed staff that may provide medication assistance under the general supervision of a Florida-licensed registered nurse.[5]

Terminology for Day Programs and Day Habilitation Facilities

Section 393.506, F.S., refers to "day programs" as defined in s. 393.063, F.S., but s. 393.063, F.S., does not provide a definition for "day programs." Section 393.063(8), F.S., does define "day habilitation facility" and "day habilitation services."

- A "day habilitation facility" is any nonresidential facility which provides day habilitation services.

- A "day habilitation service" is a service that provides assistance with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a nonresidential setting, separate from the home or facility in which the individual resides. Day habilitation services focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech therapies listed in the plan of care.

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[2] Sections. 400.488, 400.4256, 400.9685, and 1006.062, F.S.
[3] *See* s. 464.022(1), F.S.
[4] *See* s. 393.506, F.S.
[5] *Ibid.*

PROPOSED CHANGES

The bill allows a direct service provider who is not licensed to administer medication to supervise self-administration or to administer medication to a client. The bill expands the existing provision (s. 393.506, F.S.) by allowing direct service providers to administer otic, ophthalmic and rectal prescription medications.

The bill provides that, in order to supervise self-administration of medication or to administer medications, a direct service provider must successfully complete a 4-hour training course in medication administration. The direct service provider is required to be assessed annually for competency in an onsite setting. A nurse or physician is required to observe and validate that the individual has met specified criteria such that the individual is able to administer medication to a client in a safe and sanitary manner.

The bill requires that a direct service provider must receive informed consent from the client, or the client's guardian, or legal representative, prior to supervising the self-administration of medication or administration of medication. The consent form must be accompanied with a description of the routes medication may be administered and the procedures that a direct service provider is authorized to supervise or administer.

The bill provides rule-making authority to APD so it may establish standards and procedures that a direct service provider must follow in order to supervise or administer medication to a client. The rules must include guidelines for such items as the labeling of medication, documentation and recordkeeping, storage and disposal of medication, and the training curriculum and validation procedures.

The bill removes the following provisions from s. 393.506, F.S.:

- The requirement that facilities, institutions or programs must include in its policies and procedures a plan for training designating the safe handling, storage, and administration of medications and requires that the policies and procedures be approved by the agency;
- The requirement that facilities maintain a copy of the written prescription, dosage and administration schedule, reason for the prescription, and termination date; and
- Reference to intermediate care facilities which are licensed by the Agency for Health Care Administration and are regulated pursuant to Chapter 400, F.S.

The bill changes "day programs" to "day habilitation services" to reference existing definitions within Chapter 393, F.S, and provides APD with the authority to promulgate rules.

C. SECTION DIRECTORY:

Section 1. Amends s. 393.506, F.S., to delete the requirements for unlicensed staff of direct care facilities to administer prescribed medications to persons with developmental disabilities; to authorize direct service providers to administer medication or supervise the self-administration of medication if they successfully complete a 4-hour training course on medication administration; to require APD to adopt rules to establish standards and procedures governing the supervision of direct care providers and their ability to administer mediation.

Section 2. Provides the bill will take effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Programs regulated by Chapter 393, F.S., may incur costs associated with the 4-hour training course on medication administration.

D. FISCAL COMMENTS:

There may be costs associated with rule promulgation by the Agency for Persons with Disabilities.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

This bill provides the Agency for Persons with Disabilities the authority to adopt rules to facilitate implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DRAFTING ISSUES:

On lines 54 and 55, the bill references "unlicensed" direct service provider. By definition a direct service provider is unlicensed, so the reference to unlicensed is not necessary. Other references to "unlicensed" were removed in the strike-all amendment that was adopted in the Health Care Regulation Committee.

OTHER COMMENTS:

According to the Department of Health, the Board of Nursing has client safety concerns regarding the administration of medications by unlicensed personnel and feels that any authority to do so should mimic the requirements for education/training and supervision by a registered nurse as provided in chapter 400, F.S.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 15, 2006, the Health Care Regulation Committee adopted a strike-all amendment offered by the bill's sponsor. The Committee Substitute differs from the original bill as filed in that it:

- Broadens the provisions of s. 393.506, F.S., and applies to all facilities that are regulated under chapter 393 such as: comprehensive transitional education programs, developmental disability institutions, foster care facilities, group home facilities, residential facilities, supported, living, etc. The original bill added a provision that was specific to comprehensive transitional education programs;
- Adds a 4-hour training course in medication administration;
- Removes the provision that medication may only be administered under the general supervision of a registered nurse; and
- Changes the term "unlicensed direct care staff" to "direct service provider" and consistently uses the term "direct service provider."

The bill, as amended, was reported favorably as a committee substitute. This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the administration of medication; amending s. 393.506, F.S.; deleting requirements for unlicensed staff members of direct care service facilities to administer prescribed medications to persons with developmental disabilities; authorizing direct service providers to administer medication to clients or to supervise the self-administration of medication by clients; providing requirements for direct service providers to demonstrate competency regarding supervising the self-administration of medication by clients or administering medication to clients; requiring the Agency for Persons with Disabilities to adopt rules to establish standards and procedures governing the supervision of self-administered medications and the administration of medications by direct service providers; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 393.506, Florida Statutes, is amended to read:

393.506 Administration of medication.--

(1) A ~~Notwithstanding the provisions of part I of chapter 464, the Nurse Practice Act, unlicensed~~ direct service provider who is not currently licensed to administer medication ~~care services staff providing services to persons with developmental disabilities~~ may supervise the self-administration of or may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, or topical prescription medications to a client as provided in this section.

(2) In order to supervise the self-administration of medication or to administer medications as provided in subsection (1), a direct service provider must satisfactorily complete a medication administration training course of not less than 4 hours in medication administration and be found competent to supervise the self-administration of medication by a client or to administer medication to a client in a safe and sanitary manner. Competency must be assessed and validated at least annually in an onsite setting and must include personally observing that the direct service provider satisfactorily:

(a) Supervised the self-administration of medication by a client.

(b) Administered medication to a client.

(3) A direct service provider may supervise the self-administration of medication by a client or may administer medication to a client only if the client, or the client's

guardian or legal representative, has given his or her informed consent to self-administering medication under the supervision of an unlicensed direct service provider or to receiving medication administered by an unlicensed direct service provider. Such informed consent must be based on a description of the medication routes and procedures that the direct service provider is authorized to supervise or administer. Only a direct service provider who has received appropriate training and has been validated as competent may supervise the self-administration of medication by a client or may administer medication to a client.

(4) The determination of competency and annual validation required under this section shall be conducted by a registered nurse licensed pursuant to chapter 464 or a physician licensed pursuant to chapter 458 or chapter 459.

(5) The agency shall establish by rule standards and procedures that a direct service provider must follow when supervising the self-administration of medication by a client and when administering medication to a client. Such rules must, at a minimum, address requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication or supervision of self-administered medication, informed-consent requirements and records, and the training curriculum and validation procedures.

~~(a) For day programs, as defined in s. 393.063, the director of the facility or program shall designate in writing unlicensed direct care services staff who are eligible to be~~

~~trained to assist in the administration of or to administer medication.~~

~~(b) For intermediate care facilities for the developmentally disabled licensed pursuant to part XI of chapter 400, unlicensed staff designated by the director may provide medication assistance under the general supervision of a registered nurse licensed pursuant to chapter 464.~~

~~(2) Each facility, institution, or program must include in its policies and procedures a plan for training designated staff to ensure the safe handling, storage, and administration of prescription medication. These policies and procedures must be approved by the agency before unlicensed direct care services staff assist with medication.~~

~~(3) The policies and procedures must include, at a minimum, the following provisions:~~

~~(a) An expressed and informed consent for each client.~~

~~(b) The director of the facility, program, or provider must maintain a copy of the written prescription, and that prescription must include the name of the medication, the dosage and administration schedule, the reason for the prescription, and the termination date.~~

~~(c) Each prescribed medication shall be kept in its original container and in a secure location.~~

~~(4) The training required in this section shall be conducted by a registered nurse or a physician licensed pursuant to chapter 458 or chapter 459.~~

Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 599 Florida Faith-based and Community-based Advisory Board
SPONSOR(S): Cannon and others
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 1232

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 1 N	Preston	Shaw Collins
2) Transportation & Economic Development Appropriations Committee	13 Y, 1 N	McAuliffe	Gordon
3) Health & Families Council		Preston	Moore
4)			
5)			

SUMMARY ANALYSIS

The bill statutorily establishes the Florida Faith-based and Community-based Advisory Board (board) which was created by Executive Order of the Governor in November 2004 (Number 04-245). The bill provides for the board to be administratively housed within the Executive Office of the Governor. The board is to consist of 25 members: 17 appointed by the Governor; four appointed by the President of the Senate; and four appointed by the Speaker of the House of Representatives. Members are appointed for four year terms, with the initial terms being staggered. The board must meet at least once per quarter per calendar year, and work in partnership with the Volunteer Florida Foundation, Inc., a nonprofit direct support organization.

The bill specifies the activities of the board, and requires an annual report be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives that documents the board's activities and recommended policies, priorities, and objectives for the state's effort to facilitate the involvement of faith-based, volunteer, and other community-based organizations.

The board is prohibited from recommending any public program that conflicts with the Establishment Clause of the First Amendment to the United States Constitution or Article I, section 3 of the State Constitution. The board is abolished June 30, 2011, unless reviewed and recreated by the Legislature.

There may be an insignificant fiscal impact related to state government from the bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – Members of the board may include representatives from various faiths, faith-based organizations, community-based organizations, foundations, corporations, and municipalities. Serving on the advisory board will create additional responsibilities, obligations, and work for these individuals.

B. EFFECT OF PROPOSED CHANGES:

Background

Recent state and federal actions have prompted a re-examination of the use of religious organizations for the delivery of public services. Public Law 104-193, the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," expanded the role of faith-based organizations in direct service delivery. States were authorized under s. 104 of the Act to contract with charitable, religious, and private organizations for services, provided no funds were directed toward sectarian worship, instruction, or proselytizing. Article I, section 3, of the State Constitution, provides in part that "[n]o revenue of the state or any political subdivision or agency thereof shall ever be taken from the public treasury directly or indirectly in aid of any church, sect, or religious denomination or in aid of any sectarian institution." Concurrent actions in the state, with particular reference to the Department of Corrections and its faith-based programming at Lawtey Correctional Institution, have produced renewed interest in expanding the supply of contract vendors in the hopes of reaching underserved or un-served populations that otherwise qualify for public service or intervention.

The National Conference of State Legislatures (NCSL) conducted a survey of state faith-based initiatives in all 50 states in early 2002 and reported that states that have implemented faith-based initiatives started with the creation of an office of faith-based initiatives or a state liaison for faith-based and community leaders.[1]

In November 2004, Governor Bush signed an Executive Order[2] creating a faith-based and community advisory board. The board's mission is to help state government coordinate efforts to utilize and expand opportunities for faith-based and community-based organizations to address social needs in Florida's communities. The 25-member, Governor-appointed board serves as a policy advisor to the Governor on policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

Effect of Proposed Changes

The bill codifies the existing advisory board created by Executive Order Number 04-245. The board is established in statute and assigned to the Executive Office of the Governor. The bill provides that the purpose of the board is to advise the Governor and the Legislature on policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations.

The bill provides that the board is administratively housed within the Executive Office of the Governor. The board is to consist of 25 members, with 17 appointed by the Governor; four appointed by the

[1] Jarchow, C. Faith-Based Initiatives in Welfare Reform. National Conference of State Legislatures. May 2002.
[2] Executive Order No. 04-245, November 18, 2004.

President of the Senate; and four appointed by the Speaker of the House of Representatives. Members are appointed for four year terms, with the initial terms being staggered. The board must meet at least once per quarter per calendar year.

The activities of the board are specified and an annual report is required to be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives that contains an accounting of the board's activities and recommended policies, priorities, and objectives for the state's effort to facilitate the involvement of faith-based, volunteer, and other community-based organizations in service provision.

The board is prohibited from recommending any public program that conflicts with the Establishment Clause of the First Amendment to the United States Constitution or Article I, section 3 of the State Constitution and is abolished June 30, 2011, unless reviewed and saved from repeal by the Legislature.

C. SECTION DIRECTORY:

Section 1. Creates s. 14.31, F.S., relating to the Florida Faith-based and Community-based Advisory Board.

Section 2. Provides for an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Members of the board are not entitled to compensation for their service, but may be reimbursed for per diem and travel expenses pursuant to section 112.061, Florida Statutes.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None

D. FISCAL COMMENTS:

The bill contains no appropriation for the implementation of the provisions of this bill; however, the Executive Office of the Governor states the costs related to the administration and expenses of the board could be addressed with current resources. Currently, the advisory board created by Executive Order is being funded by private sources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to take an action requiring the expenditure of funds, does not reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

None

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill codifies an existing Governor-appointed advisory board that was created in November 2004, by Executive Order of the Governor to help state government coordinate efforts to utilize and expand opportunities for faith-based and community-based organizations to address social needs in Florida's communities. The bill does not specify how the transition from a 25-member Governor-appointed board to the newly-created 25-member board with a membership appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives, will occur.

The proper term for the description of an advisory body is "Council" rather than "Board."[3]

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[3] See s. 20.03(7), Florida Statutes.

A bill to be entitled

An act relating to the Florida Faith-based and Community-based Advisory Board; creating s. 14.31, F.S.; providing legislative findings and intent; creating the Florida Faith-based and Community-based Advisory Board within the Executive Office of the Governor for certain purposes; providing for board membership; providing for terms of members; providing for successor appointments; providing for meetings and organization of the board; specifying serving without compensation; providing for per diem and travel expenses; specifying required activities of the board; specifying restricted activities; requiring a report to the Governor and Legislature; providing for future repeal and abolition of the board; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 14.31, Florida Statutes, is created to read:

14.31 Florida Faith-based and Community-based Advisory Board.--

(1) LEGISLATIVE FINDINGS.--The Legislature finds that:

(a) Compassionate groups of individuals have selflessly aided this state in serving our most vulnerable citizens and our most debilitated neighborhoods.

(b) Inspired by faith and civic commitment, these organizations have accomplished much in changing the lives of

thousands and resurrecting neighborhoods torn by the strife of crime and poverty.

(c) Many beneficial opportunities may be lost if faith-based and community-based groups are not aware of opportunities to participate with government entities in serving the citizens of this state or are not equipped to participate on an equal basis, to the full extent permitted by law, in partnering or contracting with government entities for the delivery of services pursuant to a valid governmental purpose.

(d) A fee-for-service or value-for-value contract with a faith-based or community-based organization in pursuit of a valid governmental purpose primarily aids taxpayers, not the organization, and a public program of general eligibility with a secular purpose in which faith-based or community-based organizations participate on a neutral basis is consistent with the First Amendment to the United States Constitution and s. 3, Art. I of the State Constitution.

(e) Government may not advance or inhibit religious expression or endorse any particular type of religion over nonreligion but must not discriminate against the provision of services by faith-based or community-based providers who are otherwise qualified to provide services.

(f) Volunteer Florida Foundation, Inc., is a nonprofit direct-support organization equipped to assist in securing training, technical assistance, and other support needed to accomplish the intent and purposes of this act.

(2) LEGISLATIVE INTENT.--It is therefore the intent of the Legislature to recognize the contributions of faith-based and

community-based organizations and to encourage opportunities for such organizations to partner with government entities to deliver services more effectively. The Legislature further intends that the purpose of the board is to advise the Governor and the Legislature on policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

(3) ESTABLISHMENT OF THE BOARD.--

(a) The Florida Faith-based and Community-based Advisory Board is established and assigned to the Executive Office of the Governor. The board shall be administratively housed within the Executive Office of the Governor.

(b) The board shall consist of 25 members. Board members may include, but shall not be limited to, representatives from various faiths, faith-based organizations, community-based organizations, foundations, corporations, and municipalities.

(c) The board shall be composed of the following members:

1. Seventeen members appointed by and serving at the pleasure of the Governor.

2. Four members appointed by and serving at the pleasure of the President of the Senate.

3. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

(d) Board members shall serve 4-year terms, except that the initial terms shall be staggered as follows:

1. The Governor shall appoint six members for a term of 3

years, six members for a term of 2 years, and five members for a term of 1 year.

2. The President of the Senate shall appoint two members for a term of 3 years and two members for a term of 2 years.

3. The Speaker of the House of Representatives shall appoint two members for a term of 3 years and two members for a term of 2 years.

(e) A vacancy shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(4) MEETINGS; ORGANIZATION.--

(a) The first meeting of the board shall be held no later than August 1, 2006. Thereafter, the board shall meet at least once per quarter per calendar year. Meetings may be held via teleconference or other electronic means. The board shall work in partnership with the Volunteer Florida Foundation, Inc., in noticing and coordinating all meetings of the board.

(b) The board shall annually elect from its membership one member to serve as chair of the board and one member to serve as vice chair.

(c) Thirteen members of the board shall constitute a quorum.

(d) Members of the board shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(5) SCOPE OF ACTIVITIES.--The board shall determine:

(a) How government may deliver state services with a valid governmental purpose on a neutral basis without regard to the

religious or secular perspective of faith-based and community-based organizations.

(b) How best to develop and coordinate activities of faith-based and community-based programs and initiatives, enhance such efforts in communities, and seek such resources, legislation, and regulatory relief as may be necessary to accomplish these objectives.

(c) How best to ensure that state policy decisions take into account the capacity of faith-based and other community-based initiatives to assist in the achievement of state priorities.

(d) How best to identify and promote best practices across state government relating to the delivery of services by faith-based and other community-based organizations.

(e) How best to coordinate public awareness of faith-based and community nonprofit initiatives, such as demonstration pilot programs or projects, public-private partnerships, volunteerism, and special projects.

(f) How best to encourage private charitable giving to support faith-based and community-based initiatives.

(g) How best to bring concerns, ideas, and policy options to the Governor and Legislature for assisting, strengthening, and replicating successful faith-based and other community-based programs.

(h) How best to develop and implement strategic initiatives to strengthen the institutions of families and communities in this state.

(i) How best to showcase and herald innovative grassroots

nonprofit organizations and civic initiatives.

(j) How best to eliminate unnecessary legislative, regulatory, and other bureaucratic barriers that impede effective faith-based and other community-based efforts to address social problems.

(k) How best to monitor implementation of state policy affecting faith-based and other community-based organizations.

(l) How best to ensure that the efforts of faith-based and other community-based organizations meet objective criteria for performance and accountability.

(6) RESTRICTED ACTIVITIES.--The board shall not recommend any public program that conflicts with the Establishment Clause of the First Amendment to the United States Constitution or s. 3, Art. I of the State Constitution.

(7) REPORT.--By February 1 of each year, the board shall prepare a written report for the Governor, the President of the Senate, and the Speaker of the House of Representatives containing an accounting of its activities and recommended policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community-based organizations to the full extent permitted by law.

(8) REPEAL AND ABOLITION.--This section is repealed and the board is abolished June 30, 2011, unless reviewed and saved from repeal by the Legislature.

Section 2. This act shall take effect July 1, 2006.

STRIKE-ALL AMENDMENT TO HB 599 by Rep. Cannon

- The amendment statutorily establishes the Florida Faith-based and Community-based Advisory Council which was created by Executive Order of the Governor in November 2004.

- The amendment provides for the council to be administratively housed within the Executive Office of the Governor.

- The council is to consist of 25 members: 17 appointed by the Governor; four appointed by the President of the Senate; and four appointed by the Speaker of the House of Representatives.

- Members are appointed for four year terms, with the initial terms being staggered. The council must meet at least once per quarter per calendar year.

- The amendment specifies the activities of the council, and requires an annual report be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives that documents the council's activities and recommended policies, priorities, and objectives for the state's effort to facilitate the involvement of faith-based, volunteer, and other community-based organizations.

- The council is prohibited from recommending any public program that conflicts with the Establishment Clause of the First Amendment to the United States Constitution or Article I, section 3 of the State Constitution.

- The council is abolished June 30, 2011, unless reviewed and recreated by the Legislature.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (for drafter's use only)

Bill No. **0599**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Cannon offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 14.31, Florida Statutes, is created to read:

14.31 Florida Faith-based and Community-based Advisory Council.--

(1) LEGISLATIVE FINDINGS.--The Legislature finds that:

(a) Compassionate groups of individuals have selflessly aided this state in serving our most vulnerable residents and our most debilitated neighborhoods.

(b) Inspired by faith and civic commitment, these organizations have accomplished much in changing the lives of thousands and resurrecting neighborhoods torn by the strife of crime and poverty.

(c) It is essential that this state cooperate with these organizations in order to create a level playing field, regardless of each organization's orientation, whether faith-based or secular.

(2) LEGISLATIVE INTENT.--It is therefore the intent of the Legislature to recognize the contributions of these organizations and to encourage opportunities for faith-based and community-based organizations to work cooperatively with government entities in order to deliver services more effectively. The Legislature further intends that the purpose of the council is to advise the Governor and the Legislature on policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

(3) ESTABLISHMENT OF THE COUNCIL.--

(a) The Florida Faith-based and Community-based Advisory Council, an advisory council as defined in s. 20.03(7), is established and assigned to the Executive Office of the Governor. The council shall be administratively housed within the Executive Office of the Governor.

(b) The council shall consist of 25 members. Council members may include, but need not be limited to, representatives from various faiths, faith-based organizations, community-based organizations, foundations, corporations, and municipalities.

(c) The council shall be composed of the following members:

1. Seventeen members appointed by and serving at the pleasure of the Governor.

2. Four members appointed by and serving at the pleasure of the President of the Senate.

3. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

(d) Council members shall be appointed to 4-year terms, except that the initial terms shall be staggered:

1. The Governor shall appoint six members for terms of 3 years, six members for terms of 2 years, and five members for terms of 1 year.

2. The President of the Senate shall appoint two members for terms of 3 years and two members for terms of 2 years.

3. The Speaker of the House of Representatives shall appoint two members for terms of 3 years and two members for terms of 2 years.

(e) A vacancy shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(4) MEETINGS; ORGANIZATION.--

(a) The first meeting of the council shall be held no later than August 1, 2006. Thereafter, the council shall meet at least once per quarter per calendar year. Meetings may be held via teleconference or other electronic means.

(b) The council shall annually elect from its membership one member to serve as chair of the council and one member to serve as vice chair.

(c) Thirteen members of the council shall constitute a quorum.

(d) Members of the council shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

(5) SCOPE OF ACTIVITIES.--The council shall review and recommend in a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives:

(a) How faith-based and community-based organizations can best compete with other organizations for the delivery of state services, regardless of an organization's orientation, whether faith-based or secular.

(b) How best to develop and coordinate activities of faith-based and other community programs and initiatives, enhance such efforts in communities, and seek such resources, legislation, and regulatory relief as may be necessary to accomplish these objectives.

(c) How best to ensure that state policy decisions take into account the capacity of faith-based and other community initiatives to assist in the achievement of state priorities.

(d) How best to identify and promote best practices across state government relating to the delivery of services by faith-based and other community organizations.

(e) How best to coordinate public awareness of faith-based and community nonprofit initiatives, such as demonstration pilot programs or projects, public-private partnerships, volunteerism, and special projects.

(f) How best to encourage private charitable giving to support faith-based and community initiatives.

(g) How best to bring concerns, ideas, and policy options to the Governor and Legislature for assisting, strengthening, and replicating successful faith-based and other community programs.

(h) How best to develop and implement strategic initiatives to strengthen the institutions of families and communities in this state.

(i) How best to showcase and herald innovative grassroots nonprofit organizations and civic initiatives.

(j) How best to eliminate unnecessary legislative, regulatory, and other bureaucratic barriers that impede effective faith-based and other community efforts to address social problems.

(k) How best to monitor implementation of state policy affecting faith-based and other community organizations.

(l) How best to ensure that the efforts of faith-based and other community organizations meet objective criteria for performance and accountability.

(6) RESTRICTED ACTIVITIES.--The council may not make any recommendation that is in conflict with the Establishment Clause of the First Amendment to the United States Constitution or the public funding provision of s. 3, Art. I, of the State Constitution.

(7) REPORT.--By February 1 of each year, the council shall prepare a written report for the Governor, the President of the Senate, and the Speaker of the House of Representatives containing an accounting of its activities and recommended policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

(8) EXPIRATION.--This section expires and the council is abolished June 30, 2011, unless reviewed and saved from repeal by the Legislature.

Section 2. This act shall take effect July 1, 2006.

========== T I T L E A M E N D M E N T ==========

Remove the entire title and insert:

A bill to be entitled

An act relating to the Florida Faith-based and Community-based Advisory Council; creating s. 14.31, F.S.; providing legislative findings and intent; creating the Florida Faith-based and Community-based Advisory Council within the Executive Office of the Governor for certain purposes;

providing for council membership; providing for terms of members; providing for successor appointments; providing for meetings and organization of the council; specifying serving without compensation; providing for per diem and travel expenses; specifying required activities of the council; specifying restricted activities; requiring a report to the Governor and Legislature; providing for future repeal and abolition of the council; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 859 CS Physician Assistants
SPONSOR(S): Baxley
TIED BILLS: **IDEN./SIM. BILLS:** SB 1690

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	8 Y, 0 N, w/CS	Hamrick	Mitchell
2) Health & Families Council		Hamrick LH	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 859 CS requires that a licensed physician assistant, designated by the Council on Physician Assistants, participate in a probable cause panel considering disciplinary action against a licensed physician assistant. If the designated physician assistant is not available, the probable cause panel may consider and vote on the case in their absence.

Identical language is added to the practice acts for allopathic and osteopathic physicians. Licensure of the two professions is performed by separate boards and each has a separate probable cause panel. The bill provides an exemption for required disciplinary training for the physician assistant.

The bill does not appear to have a significant fiscal impact on state or local governments.

The bill takes effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility-The bill provides that a physician assistant who is under investigation by a probable cause panel will have a physician assistant sit on the probable cause panel. This provides physician assistants a voice in determining the disciplinary action of members of their profession.

B. EFFECT OF PROPOSED CHANGES:

The bill requires that when a probable cause panel is considering disciplinary action against a physician assistant, the probable cause panel of the Board of Medicine or Osteopathic Medicine must include a physician assistant that is designated by the Council on Physician Assistants. The designated physician assistant must hold an active Florida license and may only participate in cases considering disciplinary action against a physician assistant. If the designated physician assistant is not available, the probable cause panel may consider and vote on the case in their absence. The bill exempts the designated physician assistant from having to attend a disciplinary training program (s. 458.307(4), F.S.) and clarifies that rule making authority is not required to implement the provisions of the bill (s. 456.073(4), F.S).

PRESENT SITUATION

Currently, there are about 3,000 licensed physician assistants and 33,000 licensed allopathic and osteopathic physicians in Florida. Physician assistants practice under the indirect supervision of allopathic and osteopathic physicians. Physician assistants are governed under identical provisions within the practice act for medicine and osteopathic medicine respectively, ss. 458.347 and 459.022. F.S.

Council on Physician Assistants

The Council on Physician Assistants is created within the Department of Health and consists of five members: 3 doctors from the Board of Medicine, one of whom must supervise a physician assistant, 1 doctor from the Board of Osteopathic Medicine, and 1 licensed physician assistant appointed by the Secretary of the department. The Council on Physician Assistants may not adopt rules unless they are accepted and approved by the Board of Medicine and the Board of Osteopathic Medicine.

The Board of Medicine or the Board of Osteopathic Medicine may impose any of the penalties on physician assistants that are authorized in ss. 456.072 and 458.331(2) or 459.015(2), F.S.

Membership Requirements for Probable Cause Panels

Section 456.073(4), F.S. provides that a probable cause panel must be composed of at least two members; one or more of the members may be a former board member; one member must be one of the board's former or present consumer members, if one is available. Any probable cause panel must include a former or present professional board member with an active license for the profession they are representing.

Disciplinary Training Program

Section 458.307(4), F.S., provides that no member of the Board of Medicine will participate or be part of a probable cause panel unless he or she has completed a disciplinary training program. The disciplinary training program provides probable cause members the knowledge needed to determine the grounds for disciplinary action, changes in relevant statutes and rules, and any relevant judicial and administrative decisions. The bill provides a specific exemption for the physician assistant from having to attend this training.

C. SECTION DIRECTORY:

Section 1. Amends s. 458.331, F.S., to require that when a probable cause panel is considering disciplinary action against a physician assistant, the probable cause panel of the Board of Medicine must include a physician assistant who is recommended by the Council on Physician Assistants and exempts certain rule making and training provisions.
Section 2. Amends s. 459.015, F.S., to require that when a probable cause panel is considering disciplinary action against a physician assistant, the probable cause panel of the Board of Osteopathic Medicine must include a physician assistant who is recommended by the Council on Physician Assistants and exempts certain rule making provisions.
Section 5. Provides that this bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the Department of Health, there will be some costs involved in having an additional person attend a probable cause panel meeting. The cost will not be significant.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is needed to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 15, 2006, the Health Care Regulation Committee adopted a strike-all amendment offered by the bill's sponsor. The Committee Substitute differs from the original bill as filed in that it removed the provision deleting the requirement that a physician must cosign medical charts and records that are prepared by a physician assistant and added language that exempts the physician assistant from having to attend the disciplinary training program.

The bill, as amended, was reported favorably as a committee substitute.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to probable cause panels; amending ss. 458.331 and 459.015, F.S.; placing a physician assistant on probable cause panels of the Board of Medicine and the Board of Osteopathic Medicine considering discipline of physician assistants; providing that certain rulemaking provisions are not required to implement specified probable cause panel provisions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (2) of section 458.331, Florida Statutes, is amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(2) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of

violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1). A probable cause panel considering disciplinary action against a physician assistant under s. 456.073 must include one physician assistant holding an active license to practice as a physician assistant who has been designated by the Council on Physician Assistants. The designated physician assistant shall only hear cases involving disciplinary action against physician assistants. If the designated physician assistant is not available at the time the case is heard, the panel may consider and vote on the case in the absence of the designated physician assistant. The training requirement set forth in s. 458.307(4) does not apply to the designated physician assistant. Rulemaking as set forth in s. 456.073(4) is not required to implement this subsection. In determining what action is appropriate, the board must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the physician. All costs associated with compliance with orders issued under this subsection are the obligation of the physician.

Section 2. Subsection (2) of section 459.015, Florida Statutes, is amended to read:

459.015 Grounds for disciplinary action; action by the board and department.--

(2) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any

applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1). A probable cause panel considering disciplinary action against a physician assistant under s. 456.073 must include one physician assistant holding an active license to practice as a physician assistant who has been designated by the Council on Physician Assistants. The designated physician assistant shall only hear cases involving disciplinary action against physician assistants. If the designated physician assistant is not available at the time the case is heard, the panel may consider and vote on the case in the absence of the designated physician assistant. Rulemaking as set forth in s. 456.073(4) is not required to implement this subsection. In determining what action is appropriate, the board must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the physician. All costs associated with compliance with orders issued under this subsection are the obligation of the physician.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 903 CS Pharmacy Common Databases
SPONSOR(S): Traviesa
TIED BILLS: **IDEN./SIM. BILLS:** SB 1838

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	11 Y, 0 N	Bell	Mitchell
2) Health Care Appropriations Committee	15 Y, 0 N, w/CS	Money	Massengale
3) Health & Families Council		Bell FCB	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 903 CS changes the way Schedule II prescription drugs are processed when transferred to another pharmacy. Schedule II prescription drugs are drugs that have high potential for abuse and may lead to psychological dependence. Currently, mail-order pharmacy benefit managers (PBMs) must physically or electronically send a Schedule II prescription to their automated dispensing operation, before dispensing Schedule II prescriptions. The bill removes this regulatory step in the mail-order prescription dispensing process.

The bill creates section 456.0266, F.S., to allow the dispensing and refilling of a prescription, including Schedule II prescription drugs, that is on file in a pharmacy located anywhere in the United States. The bill proposes the following stipulations that must be met for mail-order pharmacies to transfer a prescription:

- The participating pharmacies must have the same owner and share a common database.
- The prescription information must be maintained within the common database.
- The common database must maintain a record of all persons involved, in any manner, in the dispensing or refilling of the prescription.
- All participating pharmacies must be properly licensed by their state of residence.
- The owner of the common database shall ensure that it maintains a policy and procedures manual that governs its participating pharmacies and pharmacists, which shall be made available to the board or its agent upon request.

The fiscal impact to state government cannot be determined. [See II. D. Fiscal Comments]

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill allows pharmacies that have the same owner and share a common database to dispense Schedule II prescription drugs without physically transferring the prescription from one location to another.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

The transfer of Schedule II prescriptions is currently necessary for mail order prescription drug companies. Usually a "front-end" pharmacy processes the prescription and makes several checks before sending the prescription to the "back-end" pharmacy through a common database. The back-end pharmacy is automated and responsible for mailing out prescriptions. Currently, Schedule II prescriptions must be sent to the back-end pharmacy even if both the pharmacies share a common owner and database.

Section 465.026(7), F.S., establishes conditions under which a community pharmacy can transfer prescriptions for drugs listed in Schedule II. Under chapter 893, F.S., Schedule II drugs are defined as drugs that have a high potential for abuse, are currently accepted for medical use in treatment in the United States, and may lead to serious psychological dependence. Codeine, morphine, and methadone are all examples of Schedule II drugs.

Section 465.026(7), F.S., outlines the transfer of a prescription verbally or by electronic means to the receiving pharmacy. The transfer procedure is outlined in sections 465.026(1)-(5), and 465.026(7), F.S.

Subsections 465.026(1)-(5), F.S., require that prior to dispensing any transferred prescription a number of safety precautions are taken by the pharmacist:

- Specifying that the sending pharmacy must cancel their prescription order;
- Placing the responsibility for ensuring the accurate dispensing of the medication on the receiving pharmacy;
- Requiring the dispensing pharmacy to advise the patient that the prescription on file at the sending pharmacy must be canceled;
- Placing responsibility on the receiving pharmacist to exercise professional judgment in validating the transferred prescription;
- Providing that it is the responsibility of the pharmacy or pharmacist in the State of Florida to verify that the receiving pharmacy or pharmacist is properly licensed; and
- Providing special restrictions on the transfer of prescriptions for Schedule II controlled substances.

Effects of the Bill

House Bill 903 CS repeals the provisions in section 465.026(7), F.S., which establish conditions for a pharmacy to transfer Schedule II prescription drugs.

The bill creates section 456.0266, F.S., to allow the dispensing or refilling of a prescription, including Schedule II prescription drugs, that are on file in a pharmacy located in this state or in another state by a pharmacist located in this state or in another state, without the physical transfer of prescription (postal mail) if the following criteria are met:

- The participating pharmacies have the same owner and share a common database.
- The prescription information is maintained within the common database.
- The common database maintains a record of all persons involved, in any manner, in the dispensing or refilling of the prescription.
- All participating pharmacies are properly licensed by their state of residence.
- The owner of the common database shall ensure that it maintains a policy and procedures manual that governs its participating pharmacies and pharmacists, which shall be made available to the board or its agent upon request, and requires that the manual contain the following information:
    - A best practices model detailing how each pharmacy/pharmacist accessing the database will comply with federal and state laws, rules and regulations.
    - The procedure for maintaining appropriate records for regulatory oversight for tracking the prescription during each stage of the filling and dispensing process, identifying the pharmacists involved, and responding to information requests made by the board pursuant to section 465.1056, F.S..
    - The policy and procedure for providing adequate security to protect the confidentiality and integrity of patient information.
    - A quality assurance program.

The bill allows an out-of-state pharmacist to perform all or part of the dispensing of a prescription without being licensed in Florida or being subject to regulation in Florida. Under the new provisions, there is no one pharmacist responsible for the filling of a prescription. A pharmacist is only responsible for the actual task performed (i.e., the counting of pills).

The bill requires the owner of the common database to maintain a policy and procedures manual to govern its participating pharmacies and pharmacists.

The effective date of the bill is July 1, 2006.

BACKGROUND

Pharmacy Benefit Managers

Pharmacy benefit managers (PBMs) are companies under contract with managed care organizations, self-insured companies, and government programs to manage pharmacy network management, drug utilization review, outcomes management, and disease management. Medco, Caremark, and Express Scripts are three of the largest PBMs operating in the United States. The primary objective of the PBM is to save money. To this end, PBMs generally fill drug prescriptions by mail order as part of a corporate health insurance plan.

The "front-end" pharmacy of the mail order PBM operation usually receives prescriptions, performs pharmacist verification, and processes prescriptions through a drug utilization review. The "back-end" pharmacy usually communicates with the front-end pharmacy through a common database. The primary function of the back-end pharmacy is to perform automated prescription fulfillment functions.

C. SECTION DIRECTORY:

Section 1. - Amends s. 465.026, F. S., to repeal a provision that allows community pharmacies to transfer and dispense Schedule II prescriptions.

Section 2. - Creates s. 456.0266, F. S., to provide that pharmacies with a common database may dispense or refill a prescription on file without the physical transfer of a prescription.

Section 3. - Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would allow pharmacists that enter Schedule II prescription drugs at one location to dispense the same drugs at a different location without transferring the physical prescription. The savings incurred by the company by skipping this step may be passed on to the customer.

D. FISCAL COMMENTS:

According to the Department of Health (DOH), it is difficult to estimate how many out of state pharmacies will register as an internet or nonresident pharmacy. If only a few nonresident or internet pharmacies register, there will be a minimal fiscal impact on the Department of Health (DOH).

If a large number of nonresident and internet pharmacies register with the DOH, there will be a greater fiscal impact to DOH. More registrants will result in more disciplinary actions pursued by the DOH, and there will be additional costs associated with inspecting pharmacies, and investigating and prosecuting disciplinary violations. To manage the increased workload, DOH would have to hire more staff.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Health has the necessary rule-making authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Federal law 21 CFR 1306.11 requires that the original hard copy prescription for a Schedule II controlled substance is maintained at the dispensing pharmacy. The proposed bill seems to allow dispensing of a Substance II drug without transferring the hard copy of the prescription to the "back-end" pharmacy.

According to the federal Drug Enforcement Administration (DEA), the transfer from a "front-end" pharmacy to a "back-end" pharmacy that communicates through a common database is allowable under current regulation (federal law). The entry of prescription information into a centralized database system at one location and the ultimate dispensing of the same prescription from another location, which is owned and operated by the same company is not considered a prescription transfer by the DEA.[1]

HB 903 CS and CS/SB1838 (currently in the Health and Families Council) are identical.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 17, 2006 the Health Care Appropriations Committee adopted the following strike-all amendment that made the following changes:

- Specifies that the owner of the common database ensure that it maintains a policy and procedures manual that governs its participating pharmacies and pharmacists.
- Specifies that the manual be made available to the board or its agent upon request.
- Requires that the manual include the following information:
  - A best practices model detailing how each pharmacy/pharmacist accessing the database will comply with federal and state laws, rules and regulations.
  - The procedure for maintaining appropriate records for regulatory oversight for tracking the prescription during each stage of the filling and dispensing process, identifying the pharmacists involved, and responding to information requests made by the board pursuant to section 465.1056, F.S..
  - The policy and procedure for providing adequate security to protect the confidentiality and integrity of patient information.
  - A quality assurance program.

The analysis is drafted to the committee substitute.

[1] Letter from Drug Enforcement Administration to Merck-Medco, May 23, 2002.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to pharmacy common databases; amending s. 465.026, F.S.; deleting a provision authorizing certain community pharmacies to transfer prescriptions for Schedule II medicinal drugs under certain conditions; creating s. 465.0266, F.S.; authorizing the dispensing or refilling of a prescription without a transferred prescription under specified conditions; providing requirements for a policy and procedures manual that governs pharmacies and pharmacists participating in a pharmacy common database; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) of section 465.026, Florida Statutes, is amended to read:

465.026 Filling of certain prescriptions.--Nothing contained in this chapter shall be construed to prohibit a

pharmacist licensed in this state from filling or refilling a valid prescription which is on file in a pharmacy located in this state or in another state and has been transferred from one pharmacy to another by any means, including any electronic means, under the following conditions:

~~(7) A community pharmacy licensed under this chapter which only receives and transfers prescriptions for dispensing by another pharmacy may transfer a prescription for a medicinal drug listed in Schedule II under chapter 893. The pharmacy receiving the prescription may ship, mail, or deliver into this state, in any manner, the dispensed Schedule II medicinal drug under the following conditions:~~

~~(a) The pharmacy receiving and dispensing the transferred prescription maintains at all times a valid, unexpired license, permit, or registration to operate the pharmacy in compliance with the laws of the state in which the pharmacy is located and from which the medicinal drugs are dispensed;~~

~~(b) The community pharmacy and the receiving pharmacy are owned and operated by the same person and share a centralized database; and~~

~~(c) The community pharmacy assures its compliance with the federal laws and subsections (1)-(5).~~

Section 2. Section 465.0266, Florida Statues, is created to read:

465.0266 Common database.--The dispensing or refilling of a prescription on file in a pharmacy located in this state or in another state by a pharmacist licensed in this state or in

another state shall not require the transfer of the prescription if all of the following conditions are present:

(1) The participating pharmacies have the same owner and share a common database.

(2) The prescription information is maintained within the common database.

(3) The common database maintains a record of all persons involved, in any manner, in the dispensing or refilling of the prescription.

(4) All participating pharmacies are properly licensed by their state of residence.

(5) The owner of the common database maintains a policy and procedures manual that governs its participating pharmacies and pharmacists and that is available to the board or its agent upon request. The policy and procedures manual shall include the following information:

(a) A best practices model detailing how each pharmacy and each pharmacist accessing the common database will comply with applicable federal and state laws, rules, and regulations.

(b) The procedure for maintaining appropriate records for regulatory oversight for tracking a prescription during each stage of the filling and dispensing process, identifying the pharmacists involved in filling and dispensing the prescription and counseling the patient, and responding to any requests for information made by the board under s. 465.0156.

(c) The policy and procedure for providing adequate security to protect the confidentiality and integrity of patient information.

(d) A quality assurance program designed to objectively and systematically monitor, evaluate, and improve the quality and appropriateness of patient care through the use of the common database.

Section 3. This act shall take effect July 1, 2006.

HB 903 CS Amendment by Rep. Traviesa

The amendment provides that no Florida licensed pharmacist is responsible for the acts and omissions of another person participating in the dispensing process, unless the pharmacist is directly supervising him or her. The amendment provides that prescriptions dispensed via a common database are not "transferred."

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. _____ (for drafter's use only)

Bill No. **HB 903 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Traviesa offered the following:

Amendment (with directory and title amendments)

Remove line(s) 48-82 and insert:

Section 2. Section 465.0266, Florida Statutes, is created to read:

465.0266 Common database.--Nothing contained in this chapter shall be construed to prohibit the dispensing by a pharmacist licensed in this state or another state of a prescription contained in a common database, and such dispensing shall not constitute a transfer as defined in section 465.026 (1)-(6), provided that the following conditions are met:

(1) All pharmacies involved in the transactions pursuant to which the prescription is dispensed are under common ownership and utilize a common database.

(2) All pharmacies involved in the transactions pursuant to which the prescription is dispensed and all pharmacists engaging in dispensing functions are properly licensed, permitted or registered in this state or another state.

(3) The common database maintains a record of all pharmacists involved in the process of dispensing a prescription.

(4) The owner of the common database maintains a policy and procedures manual that governs its participating pharmacies, pharmacists and pharmacy employees and that is available to the board or its agent upon request. The policy and procedures manual shall include the following information:

(a) A best practices model detailing how each pharmacy and each pharmacist accessing the common database will comply with applicable federal and state laws, rules, and regulations.

(b) The procedure for maintaining appropriate records for regulatory oversight for tracking a prescription during each stage of the filling and dispensing process, identifying the pharmacists involved in filling and dispensing the prescription and counseling the patient, and responding to any requests for information made by the board under s. 465.0156.

(c) The policy and procedure for providing adequate security to protect the confidentiality and integrity of patient information.

(d) A quality assurance program designed to objectively and systematically monitor, evaluate, and improve the quality and appropriateness of patient care through the use of the common database.

Any pharmacist dispensing a prescription has at all times the right and obligation to exercise his or her independent professional judgment. Notwithstanding other provisions in this section, no Florida licensed pharmacist participating in the dispensing of a prescription pursuant to this section shall be

52 responsible for the acts and omissions of another person
53 participating in the dispensing process provided such person is
54 not under the direct supervision and control of the Florida
55 licensed pharmacist.
56
57 ========== T I T L E A M E N D M E N T ==========
58 Remove line(s) 11-13 and insert:
59
60 creating s. 465.0266, F.S.; authorizing the dispensing
61 or refilling of a prescription under specified
62 conditions; providing

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/SB 1838 Pharmacy Common Databases
SPONSOR(S): Health Care, Haridopolos
TIED BILLS: **IDEN./SIM. BILLS:** HB 903 CS

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health & Families Council		Bell AJB	Moore MAM
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

CS/SB 1838 changes the way Schedule II prescription drugs are processed when transferred to another pharmacy. Schedule II prescription drugs are drugs that have high potential for abuse and may lead to psychological dependence. Currently, mail-order pharmacy benefit managers (PBMs) must physically or electronically send a Schedule II prescription to their automated dispensing operation, before dispensing Schedule II prescriptions. The bill removes this regulatory step in the mail-order prescription dispensing process.

The bill creates section 456.0266, F.S., to allow the dispensing and refilling of a prescription, including Schedule II prescription drugs, that is on file in a pharmacy located anywhere in the United States. The bill proposes the following stipulations that must be met for mail-order pharmacies to transfer a prescription:

- The participating pharmacies must have the same owner and share a common database.
- The prescription information must be maintained within the common database.
- The common database must maintain a record of all persons involved, in any manner, in the dispensing or refilling of the prescription.
- All participating pharmacies must be properly licensed by their state of residence.
- The owner of the common database shall ensure that it maintains a policy and procedures manual that governs its participating pharmacies and pharmacists, which shall be made available to the board or its agent upon request.

The fiscal impact to state government cannot be determined. [See II. D. Fiscal Comments]

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill allows pharmacies that have the same owner and share a common database to dispense Schedule II prescription drugs without physically transferring the prescription from one location to another.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

The transfer of Schedule II prescriptions is currently necessary for mail order prescription drug companies. Usually a "front-end" pharmacy processes the prescription and makes several checks before sending the prescription to the "back-end" pharmacy through a common database. The back-end pharmacy is automated and responsible for mailing out prescriptions. Currently, Schedule II prescriptions must be sent to the back-end pharmacy even if both the pharmacies share a common owner and database.

Section 465.026(7), F.S., establishes conditions under which a community pharmacy can transfer prescriptions for drugs listed in Schedule II. Under chapter 893, F.S., Schedule II drugs are defined as drugs that have a high potential for abuse, are currently accepted for medical use in treatment in the United States, and may lead to serious psychological dependence. Codeine, morphine, and methadone are all examples of Schedule II drugs.

Section 465.026(7), F.S., outlines the transfer of a prescription verbally or by electronic means to the receiving pharmacy. The transfer procedure is outlined in sections 465.026(1)-(5), and 465.026(7), F.S.

Subsections 465.026(1)-(5), F.S., require that prior to dispensing any transferred prescription a number of safety precautions are taken by the pharmacist:

- Specifying that the sending pharmacy must cancel their prescription order;
- Placing the responsibility for ensuring the accurate dispensing of the medication on the receiving pharmacy;
- Requiring the dispensing pharmacy to advise the patient that the prescription on file at the sending pharmacy must be canceled;
- Placing responsibility on the receiving pharmacist to exercise professional judgment in validating the transferred prescription;
- Providing that it is the responsibility of the pharmacy or pharmacist in the State of Florida to verify that the receiving pharmacy or pharmacist is properly licensed; and
- Providing special restrictions on the transfer of prescriptions for Schedule II controlled substances.

Effects of the Bill

CS/SB 1838 repeals the provisions in section 465.026(7), F.S., which establish conditions for a pharmacy to transfer Schedule II prescription drugs.

The bill creates section 456.0266, F.S., to allow the dispensing or refilling of a prescription, including Schedule II prescription drugs, that are on file in a pharmacy located in this state or in another state by a pharmacist located in this state or in another state, without the physical transfer of prescription (postal mail) if the following criteria are met:

- The participating pharmacies have the same owner and share a common database.
- The prescription information is maintained within the common database.
- The common database maintains a record of all persons involved, in any manner, in the dispensing or refilling of the prescription.
- All participating pharmacies are properly licensed by their state of residence.
- The owner of the common database shall ensure that it maintains a policy and procedures manual that governs its participating pharmacies and pharmacists, which shall be made available to the board or its agent upon request, and requires that the manual contain the following information:
    - A best practices model detailing how each pharmacy/pharmacist accessing the database will comply with federal and state laws, rules and regulations.
    - The procedure for maintaining appropriate records for regulatory oversight for tracking the prescription during each stage of the filling and dispensing process, identifying the pharmacists involved, and responding to information requests made by the board pursuant to section 465.1056, F.S..
    - The policy and procedure for providing adequate security to protect the confidentiality and integrity of patient information.
    - A quality assurance program.

The bill allows an out-of-state pharmacist to perform all or part of the dispensing of a prescription without being licensed in Florida or being subject to regulation in Florida. Under the new provisions, there is no one pharmacist responsible for the filling of a prescription. A pharmacist is only responsible for the actual task performed (i.e., the counting of pills).

The bill requires the owner of the common database to maintain a policy and procedures manual to govern its participating pharmacies and pharmacists.

The effective date of the bill is July 1, 2006.

BACKGROUND

Pharmacy Benefit Managers

Pharmacy benefit managers (PBMs) are companies under contract with managed care organizations, self-insured companies, and government programs to manage pharmacy network management, drug utilization review, outcomes management, and disease management. Medco, Caremark, and Express Scripts are three of the largest PBMs operating in the United States. The primary objective of the PBM is to save money. To this end, PBMs generally fill drug prescriptions by mail order as part of a corporate health insurance plan.

The "front-end" pharmacy of the mail order PBM operation usually receives prescriptions, performs pharmacist verification, and processes prescriptions through a drug utilization review. The "back-end" pharmacy usually communicates with the front-end pharmacy through a common database. The primary function of the back-end pharmacy is to perform automated prescription fulfillment functions.

C. SECTION DIRECTORY:

Section 1. - Amends s. 465.026, F. S., to repeal a provision that allows community pharmacies to transfer and dispense Schedule II prescriptions.

Section 2. - Creates s. 456.0266, F. S., to provide that pharmacies with a common database may dispense or refill a prescription on file without the physical transfer of a prescription.

Section 3. - Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would allow pharmacists that enter Schedule II prescription drugs at one location to dispense the same drugs at a different location without transferring the physical prescription. The savings incurred by the company by skipping this step may be passed on to the customer.

D. FISCAL COMMENTS:

According to the Department of Health (DOH), it is difficult to estimate how many out of state pharmacies will register as an internet or nonresident pharmacy. If only a few nonresident or internet pharmacies register, there will be a minimal fiscal impact on the Department of Health (DOH).

If a large number of nonresident and internet pharmacies register with the DOH, there will be a greater fiscal impact to DOH. More registrants will result in more disciplinary actions pursued by the DOH, and there will be additional costs associated with inspecting pharmacies, and investigating and prosecuting disciplinary violations. To manage the increased workload, DOH would have to hire more staff.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Health has the necessary rule-making authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

HB 903 CS and CS/SB 1838 (currently in the Health and Families Council) are identical.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

By the Committee on Health Care; and Senator Haridopolos

587-1908-06

A bill to be entitled

An act relating to pharmacy common databases; amending s. 465.026, F.S.; deleting a provision authorizing certain community pharmacies to transfer prescriptions for Schedule II medicinal drugs under certain conditions; creating s. 465.0266, F.S.; authorizing the dispensing or refilling of a prescription without a transferred prescription under specified conditions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) of section 465.026, Florida Statutes, is amended to read:

465.026 Filling of certain prescriptions.--Nothing contained in this chapter shall be construed to prohibit a pharmacist licensed in this state from filling or refilling a valid prescription which is on file in a pharmacy located in this state or in another state and has been transferred from one pharmacy to another by any means, including any electronic means, under the following conditions:

~~(7) A community pharmacy licensed under this chapter which only receives and transfers prescriptions for dispensing by another pharmacy may transfer a prescription for a medicinal drug listed in Schedule II under chapter 893. The pharmacy receiving the prescription may ship, mail, or deliver into this state, in any manner, the dispensed Schedule II medicinal drug under the following conditions.~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

~~(a) The pharmacy receiving and dispensing the transferred prescription maintains at all times a valid, unexpired license, permit, or registration to operate the pharmacy in compliance with the laws of the state in which the pharmacy is located and from which the medicinal drugs are dispensed;~~

~~(b) The community pharmacy and the receiving pharmacy are owned and operated by the same person and share a centralized database; and~~

~~(c) The community pharmacy assures its compliance with the federal laws and subsections (1)-(5).~~

Section 2. Section 465.0266, Florida Statues, is created to read:

465.0266 Common database.--The dispensing or refilling of a prescription on file in a pharmacy located in this state or in another state by a pharmacist licensed in this state or in another state shall not require the transfer of the prescription if all of the following conditions are present:

(1) The participating pharmacies have the same owner and share a common database.

(2) The prescription information is maintained within the common database.

(3) The common database maintains a record of all persons involved, in any manner, in the dispensing or refilling of the prescription.

(4) All participating pharmacies are properly licensed by their state of residence.

(5) The owner of the common database maintains a policy and procedures manual that governs the participating pharmacies and pharmacists, which shall be made available to

the board upon request. The manual shall include the following information:

(a) A best-practices model detailing how each pharmacy and pharmacist accessing the common database will comply with applicable federal and state laws, rules, and regulations;

(b) The procedure for maintaining appropriate records for regulatory oversight for tracking the prescription during each stage of the filling and dispensing process, identifying the pharmacists involved in filling and dispensing the prescription and counseling the patient, and responding to requests for information made by the board pursuant to s. 465.0156;

(c) The policy and procedures to provide adequate security to protect the confidentiality and integrity of patient information; and

(d) A quality assurance program designed to objectively and systematically monitor, evaluate, and improve the quality and appropriateness of patient care through the use of the common database.

Section 3. This act shall take effect July 1, 2006.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 1838

The committee substitute revises conditions that must be met for a pharmacy to dispense or fill a prescription without transferring the prescription. The committee substitute requires the owner of a common database to maintain a policy and procedures manual with specified elements that governs participating pharmacies and pharmacists.

CS/SB 1838 Amendment by Rep. Traviesa

The amendment provides that no Florida licensed pharmacist is responsible for the acts and omissions of another person participating in the dispensing process, unless the pharmacist is directly supervising him or her. The amendment provides that prescriptions dispensed via a common database are not "transferred."

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. _____ (for drafter's use only)

Bill No. **CS/SB 1838**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Traviesa offered the following:

Amendment (with directory and title amendments)

On page 2, line 14, through page 3, line 19

Remove all of said lines, and insert:

Section 2. Section 465.0266, Florida Statutes, is created to read:

465.0266 Common database.--Nothing contained in this chapter shall be construed to prohibit the dispensing by a pharmacist licensed in this state or another state of a prescription contained in a common database, and such dispensing shall not constitute a transfer as defined in section 465.026 (1)-(6), provided that the following conditions are met:

(1) All pharmacies involved in the transactions pursuant to which the prescription is dispensed are under common ownership and utilize a common database.

(2) All pharmacies involved in the transactions pursuant to which the prescription is dispensed and all pharmacists

engaging in dispensing functions are properly licensed, permitted or registered in this state or another state.

(3) The common database maintains a record of all pharmacists involved in the process of dispensing a prescription.

(4) The owner of the common database maintains a policy and procedures manual that governs its participating pharmacies, pharmacists and pharmacy employees and that is available to the board or its agent upon request. The policy and procedures manual shall include the following information:

(a) A best practices model detailing how each pharmacy and each pharmacist accessing the common database will comply with applicable federal and state laws, rules, and regulations.

(b) The procedure for maintaining appropriate records for regulatory oversight for tracking a prescription during each stage of the filling and dispensing process, identifying the pharmacists involved in filling and dispensing the prescription and counseling the patient, and responding to any requests for information made by the board under s. 465.0156.

(c) The policy and procedure for providing adequate security to protect the confidentiality and integrity of patient information.

(d) A quality assurance program designed to objectively and systematically monitor, evaluate, and improve the quality and appropriateness of patient care through the use of the common database.

Any pharmacist dispensing a prescription has at all times the right and obligation to exercise his or her independent professional judgment. Notwithstanding other provisions in this

section, no Florida licensed pharmacist participating in the dispensing of a prescription pursuant to this section shall be responsible for the acts and omissions of another person participating in the dispensing process provided such person is not under the direct supervision and control of the Florida licensed pharmacist.

========== T I T L E A M E N D M E N T ==========

Remove line(s) 9-10 and insert:

under specified conditions; providing an effective

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1067 CS State Long-Term Care Ombudsman Program
SPONSOR(S): Grimsley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1922

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee	7 Y, 0 N, w/CS	DePalma	Walsh
2) Governmental Operations Committee	7 Y, 0 N, w/CS	Brown	Williamson
3) Health Care Appropriations Committee	13 Y, 0 N	Massengale	Massengale
4) Health & Families Council		DePalma	Moore
5)			

SUMMARY ANALYSIS

The bill specifies duties and responsibilities of the Office of State Long-Term Care Ombudsman and the program's state and local ombudsman councils in an attempt to fully implement the Legislature's intent in moving the program under the administration of the Department of Elderly Affairs.

The Department of Elderly Affairs reports no fiscal impact associated with this bill.

The bill provides that this act is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill increases rulemaking authority regarding council membership. The bill requires submission of an annual report regarding the performance of the state and local councils.

Empower Families—The bill streamlines and clarifies state and local ombudsman council duties and responsibilities. These modifications seek to more effectively serve the interests of long-term care residents, and potentially improve their quality of life.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

The History and Emergence of Ombudsman Programs

The Long-Term Care Ombudsman Program began in 1972 through implementation of five state demonstration projects funded by the Department of Health, Education and Welfare.[1] The projects formed as a response to growing concerns over the conditions present in our nation's nursing facilities, the care provided therein, and the effectiveness of governmental attempts to actively police and force compliance with state and federal regulations. A year later, the Administration on Aging assumed administrative responsibility for the program, and in 1978 the Long-Term Care Ombudsman Program was amended into the Older Americans Act of 1965.[2]

Today, variations of long-term care ombudsman programs are maintained in all 50 states, the District of Columbia and Puerto Rico. The central responsibilities for all ombudsmen are outlined in Subchapter XI of the Older Americans Act[3] and include:

- Identifying, investigating and resolving complaints made by or on behalf of residents.
- Providing information to residents about long-term care services.
- Representing the interests of residents before governmental agencies and seeking administrative, legal and other remedies to protect residents.
- Analyzing, commenting on and recommending changes in laws and regulations pertaining to the health, safety, welfare and rights of residents.
- Educating and informing consumers and the general public regarding issues and concerns related to long-term care, and facilitating public comment on laws, regulations, policies and actions.
- Promoting the development of citizen organizations to participate in the program.
- Providing technical support for the development of resident and family councils to protect the well-being and rights of residents.
- Advocating for changes to improve residents' quality of life and care.

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[1] *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act*, 1995, Institute of Medicine, available at: http://www.nap.edu/catalog/9059.html.
[2] 42 U.S.C.A. s. 3001 *et seq.*
[3] 42 U.S.C.A. s. 3058g.

Florida's Long-Term Care Ombudsman Program

The state's Long-Term Care Ombudsman Program (the "program") was established as a volunteer program in 1975 and is presently administered by the Department of Elderly Affairs (DOEA).[4] The program is comprised of 17 local councils, one supervisory statewide council and more than 350 volunteer ombudsmen (each contributing an average of 20 hours per month). It provides advocacy and outreach services to residents of the state's long-term care facilities and their families in a variety of ways.

Program ombudsmen serve as advocates on behalf of residents in the following settings:[5]

Facility Type	Number of Facilities	Number of Beds
Nursing homes	812	80,889
Assisted living facilities	2,249	74,219
Adult family-care homes	469	2,023

Ombudsmen investigate and resolve complaints submitted by, or on behalf of, residents of these facilities who are 60 years of age or older.[6] In 2004, a total of 7,555 complaints were investigated by state ombudsmen.[7] The most frequent complaints made by residents of long-term care facilities were as follows:[8]

Type of Complaint	Number of Complaints
Accidents, injuries and falls	220
Improper transfer or discharge	214
Administration of medication	212
Personal hygiene	203
Call lights or requests for assistance unanswered	171

Most Frequent Complaints in Nursing Homes, 2004-2005

Type of Complaint	Number of Complaints
Administration of medication	162
Quality, quantity or variation of facility menus	139
Shortage of staff	107
Billing disputes	85
Cleanliness or housekeeping concerns	78

Most Frequent Complaints in Assisted Living Facilities and Adult Family-Care Homes, 2004-2005

In addition to its investigative capacities, the program also is responsible for monitoring the development and implementation of federal, state and local regulations affecting long-term care facilities, recommending appropriate policy changes, and maintaining a statewide reporting system capable of collecting and analyzing data and providing information on the state long-term care facilities.[9]

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[4] *Florida's Long-Term Care Ombudsman Program: Real People Helping Real People*, presentation given by the Long-Term Care Ombudsman Program before the House Committee on Elder and Long-Term Care, February 22, 2006.
[5] Statistics reported in *Florida's Long-Term Care Ombudsman Program Annual Snapshot 2004-2005: Protecting Florida's Long-Term Care Residents*, provided by the Long-Term Care Ombudsman Program.
[6] Section 400.0060, F.S.
[7] 2004 National Ombudsman Reporting System Data Tables, accessed February 28, 2006, Department of Health and Human Services Administration on Aging, available at: http://www.aoa.gov/prof/aoaprog/elder_rights/LTCombudsman/National_and_State_Data/2004nors/2004nors.asp.
[8] *Florida's Long-Term Care Ombudsman Program Annual Snapshot 2004-2005.*
[9] *Ombudsman Services*, accessed February 28, 2006, Long-Term Care Ombudsman Program, available at: http://ombudsman.myflorida.com/ombudsman_services.jsp.

Facility inspections[10] are conducted annually by program ombudsmen, and focus on the rights, health, safety and welfare of residents to ensure that facilities satisfy the numerous needs of their residents in compliance with state and federal regulations. In 2004-05, the program completed a total of 2,908 inspections statewide, reflecting approximately 82 percent of Florida's licensed long-term care facilities.[11]

The program provides technical support for the development of resident and family councils to protect the rights of residents. Each of the state's 17 local councils also participates in community education sessions for service organizations, health and nursing home associations, and other community groups in an effort to recruit additional ombudsmen and to educate the public with information about the Program.

EFFECT OF PROPOSED CHANGES

In addition to providing a multitude of technical and conforming changes, the legislation makes several substantive modifications to Part I of Chapter 400, F.S.

Definitions

The bill defines an "administrative assessment" as a review of conditions in a long-term care facility that impact the rights, health, safety, and welfare of residents with the purpose of noting needed improvement and making recommendations to enhance the quality of life for residents.

The bill also supplies definitions for both "local councils" and "state councils," and specifies that the "ombudsman" is appointed by the Secretary of DOEA to head the Office of State Long-Term Care Ombudsman.

Duties and Responsibilities of the Office of State Long-Term Care Ombudsman

The bill requires that residents, their representatives, and other interested citizens be informed about obtaining program services. The bill also clarifies that the Office of State Long-Term Care Ombudsman administers the state and local ombudsman councils—as opposed to merely providing "administrative and technical support." Moreover, the office is given explicit authority to establish and coordinate local councils, and an annual reporting requirement also is established (previously, the state council was responsible for submitting this report; the bill requires the state council to "assist" in preparation of the report). The report is intended to describe the activities of the office and councils, and it is required to combine and analyze complaint and facility condition data; evaluate resident problems; assess overall program success and compliance with provisions of the federal Older Americans Act; and provide recommendations for policy and regulatory changes, while also detailing any relevant recommendations supplied by local councils regarding program functions and activities. The report must be submitted to the secretary at least 30 days before the convening of a regular session, whereupon the secretary is required to submit the report to the United States Assistant Secretary for Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the Secretary of the Department of Children and Family Services, and the Secretary of the Agency for Health Care Administration. The bill specifies that staff members coordinating local councils are designated as representatives of the Office of State Long-Term Care Ombudsman.

Duties and Membership of the State Long-Term Ombudsman Council

The bill specifies that the State Long-Term Ombudsman Council serves as an advisory board to assist the ombudsman in reaching consensus among local councils on issues affecting either the program generally or residents individually. The bill specifies that individual members of the state council may

[10] As defined in s. 400.0073, F.S.
[11] *Florida's Long-Term Care Ombudsman Program Annual Snapshot 2004-2005.*

enter a long-term care facility involved in an appeal pursuant to newly created s. 400.0074(2), F.S., and directs the state council to work with the adult protective services program as required in ss. 415.101-415.113, F.S.

The legislation requires council membership by election, provides for removal of council members upon majority vote, and specifies that three at-large council members be appointed by the Governor after recommendation by the DOEA Secretary in consultation with the ombudsman. Each local council is provided with the authority to elect, by majority vote, a representative from among local council members to represent council interests on the state council. Whereas previously the council position of any member missing three consecutive regular meetings was declared vacant, the bill specifies that members missing three council meetings within a one-year period "may" have their seat declared vacant by the ombudsman. The bill limits the state council chair to two consecutive one-year terms, deletes the requirement that chairs must have served as state council members for at least one year, enables the council chair to create additional executive positions as needed, and provides for removal of the council chair upon a two-thirds vote of state council members at any meeting at which a quorum is present. The bill provides that a council quorum is present if more than 50 percent of all active state council members are in attendance at the same meeting. The bill prohibits the state council from voting or otherwise making decisions resulting in a recommendation that will directly impact the state council or a local council outside of a publicly-noticed meeting at which a quorum is present.

Duties and Membership of Local Long-Term Care Ombudsman Councils

In an effort to conform state law to provisions of the Older Americans Act, the bill specifies that the local ombudsman councils function under the direction of the ombudsman. The bill also provides that the state ombudsman shall designate local councils and their jurisdictional boundaries, and may create additional local councils as necessary to ensure that state residents have adequate access to program services. Also, whereas local councils presently have a duty to represent residents' rights before government agencies, the bill alters this dynamic by requiring a local council to "recommend" that the ombudsman and legal advocate seek administrative, legal and other remedies on behalf of residents.

The bill specifies that local council members must maintain their primary residence within boundaries of the council's jurisdiction, establishes minimum local council membership composition, and removes a cap on the number of volunteers that each local council can recruit. The bill eliminates language in s. 400.0069(4)(b), F.S., encouraging local councils to recruit council members who are 60 years of age or older. Guidelines for application and approval of prospective council members and removal procedures for council members are provided by the legislation. The bill eliminates the limitation on the number of 1-year terms that may be served by a local council chair, authorizes the chair to create additional executive positions as needed, and provides for removal of the council chair upon a two-thirds vote of local council members.

Consolidation of Conflict-of-Interest Provisions

The bill consolidates the various conflict of interest provisions[12] scattered throughout Part I of Chapter 400, F.S., into newly-created s. 400.0070, F.S., and requires each office employee and council member to certify that he or she has no conflict of interest. This section will prohibit the ombudsman from having a direct involvement in the licensing or certification of a long-term care facility or provider, and prevents the ombudsman's employment with, ownership of, or investment in, a long-term care facility. DOEA is required to define by rule what situations constitute conflicts of interest and the procedure by which certification of an individual indicating no conflicts of interest occurs.

Program Complaint and Investigation Procedures

[12] The provisions include ss. 400.0063(2)(b), 400.0065(3), 400.0067(4), 400.0069(4)(b) and 400.0069(10), F.S.

The bill relocates the department's rulemaking authority to develop procedures for conducting facility investigations subsequent to receiving a complaint and for conducting onsite administrative assessments of state facilities. The bill deletes the requirement of long-term care facilities to post such procedures in plain view, and specifies that an administrator refusing to allow entrance to the ombudsman or any state or local council member is considered to have interfered with such individual in the performance of his or her official duties.

State Council Administrative Assessments

The bill requires local councils to conduct, at least annually and in addition to investigations pursuant to a complaint, an onsite administrative "assessment"[13] of each nursing home, assisted living facility, and adult family-care home within its jurisdiction. Local councils also are encouraged to conduct similar onsite administrative assessments of the additional long-term care facilities within its jurisdiction. The assessments are required to be non-duplicative of other state survey and inspection efforts, and shall be conducted at a time and for duration necessary to produce the information required to carry out council duties.

Advance notice is not to be provided (except for follow-up assessments), and council members physically present are required to identify themselves and cite the relevant statutory authority for the assessment. Such assessments are not to unreasonably interfere with programs and activities of facility residents, and council members may not enter single-family residential units of a facility during an assessment without the permission of the resident or that resident's representative. Additionally, the bill provides that administrative assessments are required to be conducted in a manner that imposes no unreasonable burden on a facility.

The bill indicates that the ombudsman may authorize a state or local council member to assist another local council member in performing an assessment. The bill specifies that assessments may not be accomplished by forcible entry, but notes that an administrator refusing entry to representatives of the office or a council for the purpose of an assessment shall be considered to have interfered with such individual in the performance of his or her official duties.

Complaint Notification and Resolution Procedures

The bill requires that complaints verified as a result of an investigation or assessment and determined to require some measure of remedial action be identified in writing to the long-term care facility administrator, whereupon target dates for taking appropriate remedial action shall be established. The bill specifies that a local council chair who believes a resident's rights or welfare is being jeopardized notify the ombudsman or legal advocate. Similarly, an ombudsman who believes a facility or its employee has committed a criminal act is required to inform local law enforcement officials.

The bill deletes certain recourses available to the state council in the event a facility fails to take action upon a complaint referred to the state council by a local council, including a provision allowing for recommended agency rule and licensure changes, and a provision permitting referral of the complaint to the state attorney for prosecution. The bill specifies that a state council chair who believes residents' rights or welfare are being jeopardized shall notify the ombudsman or legal advocate.

Access to Facilities, Residents and Records

The legislation requires long-term care facilities to provide the office, councils and council members access to any portion of the facility, any resident, and his or her medical and social records for review as necessary to investigate or resolve a complaint. The bill specifies that access to resident medical and social records necessary to investigate or resolve a complaint will be granted only if a legal

[13] Presently, annual "inspections" of long-term care facilities are required by s. 400.0073, F.S., and are structurally similar to the requirements for administrative assessments in the bill.

representative of the resident refuses to give permission, the office has reasonable cause to suspect that such representative is not acting in the best interests of the resident, and the state or local council member obtains the approval of the ombudsman.

Also, the bill provides access to administrative records, policies and documents and, upon request, copies of all licensing and certification records pertaining to a facility. The bill deletes a provision allowing access to resident records where the office has reasonable cause to believe a legal representative who has refused such access is not acting in the best interests of the resident.

Department Funding[14]

The bill directs the department to meet costs of the program through funds appropriated to it and to include the costs associated with the program when developing its budget requests for consideration by the Governor. The bill allows the department to divert from the federal ombudsman appropriation an amount equal to the department's administrative cost ratio, and directs the remaining allotment from the Older Americans Act to fund direct ombudsman activities.

Statewide Uniform Reporting System

The bill shifts responsibility from DOEA to the office for maintenance of a statewide uniform reporting system, intended to collect and analyze complaint and facility condition data. Similarly, the responsibility for quarterly publishing and making available information pertaining to the number and type of complaints received is shifted from the state council to the office.

Training Requirements

The bill specifies that all council members receive a minimum of 20 hours of training upon employment with the office or approval as a council member, and 10 hours of continuing education per year thereafter. The bill requires the ombudsman to approve training curriculum and indicates that such training should address, at a minimum and in addition to other training requirements, resident confidentiality and any other topic recommended by the secretary. The bill prohibits individuals from holding themselves out as representatives of the State Long-Term Care Ombudsman Program, or conducting any program duties, unless first satisfying the training detailed in s. 400.0091, F.S., and becoming certified by the ombudsman.

C. SECTION DIRECTORY:

Section 1. Amends s. 400.0060, F.S.; providing definitions.

Section 2. Amends s. 400.0061, F.S.; revising Legislative findings and intent.

Section 3. Amends s. 400.0063, F.S.; relating to the designation and duties of the ombudsman and legal advocate.

Section 4. Amends s. 400.0065, F.S., providing duties and responsibilities of the State Long-Term Care Ombudsman Program.

Section 5. Repeals s. 400.0066, F.S., relating to the Department of Elderly Affairs' funding of the Office of State Long-Term Care Ombudsman; transfers portions of section to newly-created s. 400.0087, F.S.

Section 6. Amends s. 400.0067, F.S., providing duties and membership criteria for the State Long-Term Care Ombudsman Council.

[14] Portions of these funding requirements are contained in s. 400.0066, F.S., which the bill proposes to repeal and re-create in s. 400.0087, F.S.

Section 7. Amends s. 400.0069, F.S., providing duties and membership criteria for local long-term care ombudsman councils.

Section 8. Creates s. 400.0070, F.S., relating to ombudsman conflicts of interest.

Section 9. Amends s. 400.0071, F.S., relating to State Long-Term Care Ombudsman Program complaint procedures.

Section 10. Amends s. 400.0073, F.S., relating to council investigations.

Section 11. Creates s. 400.0074, F.S., relating to onsite administrative assessments.

Section 12. Amends s. 400.0075, F.S., relating to complaint notification and resolution procedures.

Section 13. Amends s. 400.0078, F.S., relating to citizen access to State Long-Term Care Ombudsman Program services.

Section 14. Amends s. 400.0079, F.S., relating to reporter and ombudsman immunity.

Section 15. Amends s. 400.0081, F.S., relating to facility and records access.

Section 16. Amends s. 400.0083, F.S., relating to interference, retaliation and penalties.

Section 17. Repeals s. 400.0085, F.S., relating to penalties; incorporates provision into s. 400.0083, F.S.

Section 18. Amends s. 400.0087, F.S., relating to department funding and oversight.

Section 19. Amends s. 400.0089, F.S., relating to complaint data reports.

Section 20. Amends s. 400.0091, F.S., relating to training curriculum and requirements.

Section 21. Provides that the act is effective upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

   The bill does not create, modify, amend, or eliminate a state expenditure.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not create, modify, amend, or eliminate a local revenue source.

2. Expenditures:

   The bill does not create, modify, amend, or eliminate a local expenditure.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Additional rulemaking

Section 8 of the bill requires the department to promulgate a rule to define situations that constitute a "conflict of interest," and the procedure by which an individual certifies that he or she has no conflict of interest.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

Elder and Long-Term Care Committee

At its March 8, 2006, meeting, the Committee on Elder and Long-Term Care adopted four amendments to House Bill 1067, which:

- restored language in the current definition of "resident"[15] providing that, for purposes of long-term care ombudsman services, a resident must be 60 years of age or older. Deleting this language conflicted with the jurisdiction of the Statewide Advocacy Council.[16]
- deleted bill language to s. 400.0063, F.S., indicating that the office's legal advocate was to serve as legal counsel to the state and local ombudsman councils and members in conjunction with DOEA's legal counsel. This would have raised a possible conflict of interest relating to representation.[17]
- deleted bill language specifying that state council members serve at the pleasure of the Governor.
- clarified a provision in s. 400.0081(1)(c) to indicate that, prior to obtaining access to resident medical and social records pursuant to a facility investigation or resolution of a complaint, a legal representative of the resident must refuse to grant access, the office must have reasonable cause to believe that the representative is not acting in the best interests of the resident and the state or local council member must obtain the approval of the ombudsman. In addition to conforming this section to requirements found in 42 U.S.C.A. 3058g(b)(1)(B)(ii) of the Older Americans Act, this also served to clarify that all of the above requirements --- and not merely one requirement – must be satisfied by the office, council or council member prior to obtaining access to such records.

[15] S. 400.0060(7), F.S.
[16] See generally s. 402.164(2)(b), F.S.
[17] See rules 4-1.13 and 4-5.1, Rules Regulating the Florida Bar.

The Committee favorably reported a Committee Substitute.

Governmental Operations Committee

At its March 22, 2006, meeting, the Governmental Operations Committee adopted an amendment addressing the following concerns:

- Clarifying that an "administrative assessment" means a review of conditions in a long-term care facility that impact the rights, health, safety, and welfare of residents with the purpose of noting needed improvement and making recommendations to enhance the quality of life for residents.
- Restoring current statutory language regarding the ability of certain parties to file complaints against a facility, not just the employees of a facility.
- Clarifying that the ombudsmen will work with the Department of Children & Family Services' Adult Protective Services program.
- Restoring current statutory language[18] clarifying that administrative assessments are required to be conducted in a manner that imposes no unreasonable burden on a long-term care facility.
- Providing that the department must promulgate certain procedures regarding complaints, investigations, and administrative assessments by administrative rulemaking.

The Committee reported the bill favorably with committee substitute.

[18] From s. 400.0073(5)(c), F.S., this is current law relating to "onsite administrative inspections" being deleted in another section of this bill.

CHAMBER ACTION

The Governmental Operations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the State Long-Term Care Ombudsman Program; amending s. 400.0060, F.S.; providing and revising definitions; amending s. 400.0061, F.S.; revising legislative findings and intent; amending s. 400.0063, F.S.; revising provisions relating to qualifications of the State Long-Term Care Ombudsman; revising duties of the legal advocate; amending s. 400.0065, F.S.; revising duties and responsibilities of the State Long-Term Care Ombudsman; requiring an annual report; deleting provisions relating to conflict of interest; repealing s. 400.0066, F.S., relating to the Office of State Long-Term Care Ombudsman and departments of state government; amending s. 400.0067, F.S.; revising duties and membership of the State Long-Term Care Ombudsman Council; providing for election of a local council member from each local council to provide representation on the state council; authorizing the Secretary of Elderly Affairs to recommend to the Governor appointments for at-large positions on the

state council; providing conditions for removal of members of and for filling vacancies on the state council; providing for election of officers and meetings; providing for per diem and travel expenses if approved by the ombudsman; deleting provisions relating to conflicts of interest and requests for appropriations; amending s. 400.0069, F.S.; authorizing the State Long-Term Care Ombudsman to designate and direct local long-term care ombudsman councils; requiring approval by the Secretary of Elderly Affairs of jurisdictional boundaries designated by the ombudsman; revising duties of local long-term care ombudsman councils; providing requirements and application for membership, election of officers, and meetings of local long-term care ombudsman councils; providing conditions for removal of members; providing for travel expenses for members of the council; deleting provisions relating to conflicts of interest; creating s. 400.0070, F.S.; consolidating provisions relating to conflicts of interest of the ombudsman; providing rulemaking authority to the Department of Elderly Affairs regarding conflicts of interest; amending s. 400.0071, F.S.; requiring the department to adopt rules relating to procedures for receiving, investigating, and assessing complaints against long-term care facilities; deleting provisions requiring certain approval by the Secretary of Elderly Affairs and the ombudsman and the posting and distribution of copies of such procedures; amending s. 400.0073, F.S.; providing conditions for investigations of complaints by state and

local ombudsman councils; providing that refusing to allow the ombudsman or a member of a state or local council to enter a long-term care facility is a violation of ch. 400, F.S., under certain circumstances; deleting conditions for onsite administrative inspections; creating s. 400.0074, F.S.; providing conditions and requirements for onsite administrative assessments of nursing homes, assisted living facilities, and adult family-care homes; prohibiting forcible entry of long-term care facilities; providing that refusing to allow the ombudsman or a member of a state or local council to enter a long-term care facility is a violation of ch. 400, F.S., under certain circumstances; amending s. 400.0075, F.S.; providing complaint notification procedures for state and local councils; providing circumstances in which information relating to violations by a long-term care facility is provided to a local law enforcement agency; amending s. 400.0078, F.S.; requiring information relating to the State Long-Term Care Ombudsman Program to be provided to residents of long-term care facilities or their representatives; amending s. 400.0079, F.S.; providing for immunity from liability for certain persons; amending s. 400.0081, F.S.; requiring long-term care facilities to provide the Office of State Long-Term Care Ombudsman and state and local councils and their members with access to the facility and the records and residents of the facility; authorizing rather than requiring the department to adopt rules regarding access to facilities, records,

and residents; amending s. 400.0083, F.S.; prohibiting certain actions against persons who file complaints; providing penalties; repealing s. 400.0085, F.S., relating to a penalty; amending s. 400.0087, F.S.; providing for oversight by and responsibilities of the department; requiring the department to provide certain funding for the State Long-Term Care Ombudsman Program; amending s. 400.0089, F.S.; requiring the office to maintain a data reporting system relating to complaints about and conditions in long-term care facilities and to residents therein; requiring the office to publish and include certain information in its annual report; amending s. 400.0091, F.S.; providing for training of employees of the office and members of the state and local councils; requiring the ombudsman to approve the curriculum and providing contents thereof; requiring certification of employees by the ombudsman; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 400.0060, Florida Statutes, is amended to read:

400.0060 Definitions.--When used in this part, unless the context clearly dictates otherwise ~~requires~~, the term:

(1) "Administrative assessment" means a review of conditions in a long-term care facility that impact the rights, health, safety, and welfare of residents with the purpose of

noting needed improvement and making recommendations to enhance the quality of life for residents.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Department" means the Department of Elderly Affairs.

(4) "Local council" means a local long-term care ombudsman council designated by the ombudsman pursuant to s. 400.0069. Local councils are also known as district long-term care ombudsman councils or district councils.

(5) ~~(2)~~ "Long-term care facility" means a ~~skilled~~ nursing home facility, ~~nursing facility,~~ assisted living facility, adult family-care home, board and care facility, or any other similar residential adult care facility ~~center~~.

(6) ~~(3)~~ "Office" means the Office of State Long-Term Care Ombudsman created by s. 400.0063.

(7) ~~(4)~~ "Ombudsman" means the individual appointed by the Secretary of Elderly Affairs ~~designated~~ to head the Office of State Long-Term Care Ombudsman.

(8) ~~(5)~~ "Resident" means an individual 60 years of age or older who resides in a long-term care facility.

(9) ~~(6)~~ "Secretary" means the Secretary of Elderly Affairs.

(10) "State council" means the State Long-Term Care Ombudsman Council created by s. 400.0067.

Section 2. Section 400.0061, Florida Statutes, is amended to read:

400.0061 Legislative findings and intent; long-term care facilities.--

(1) The Legislature finds that conditions in long-term care facilities in this state are such that the rights, health, safety, and welfare of residents are not fully ensured by rules of the Department of Elderly Affairs or the Agency for Health Care Administration~~,~~ or by the good faith of owners or operators of long-term care facilities. Furthermore, there is a need for a formal mechanism whereby a long-term care facility resident, a representative of a long-term care facility resident, or any other concerned citizen ~~or his or her representative~~ may make a complaint against the facility or its employees, or against other persons who are in a position to restrict, interfere with, or threaten the rights, health, safety, or welfare of a long-term care facility ~~the~~ resident. The Legislature finds that concerned citizens are often more effective advocates for ~~of~~ the rights of others than governmental agencies. The Legislature further finds that in order to be eligible to receive an allotment of funds authorized and appropriated under the federal Older Americans Act, the state must establish and operate an Office of State Long-Term Care Ombudsman, to be headed by the State Long-Term Care Ombudsman, and carry out a long-term care ombudsman program.

(2) It is the intent of the Legislature, therefore, to utilize voluntary citizen ombudsman councils under the leadership of the ombudsman, and through them to operate an ombudsman program which shall, without interference by any executive agency, undertake to discover, investigate, and determine the presence of conditions or individuals which constitute a threat to the rights, health, safety, or welfare of

the residents of long-term care facilities. To ensure that the effectiveness and efficiency of such investigations are not impeded by advance notice or delay, the Legislature intends that the ombudsman and ombudsman councils and their designated representatives not be required to obtain warrants in order to enter into or conduct investigations or onsite administrative assessments ~~inspections~~ of long-term care facilities. It is the further intent of the Legislature that the environment in long-term care facilities ~~shall~~ be conducive to the dignity and independence of residents and that investigations by ombudsman councils shall further the enforcement of laws, rules, and regulations that safeguard the health, safety, and welfare of residents.

Section 3. Section 400.0063, Florida Statutes, is amended to read:

400.0063 Establishment of Office of State Long-Term Care Ombudsman; designation of ombudsman and legal advocate.--

(1) There is created an Office of State Long-Term Care Ombudsman in the Department of Elderly Affairs.

(2)(a) The Office of State Long-Term Care Ombudsman shall be headed by the State Long-Term Care Ombudsman, who shall ~~have expertise and experience in the fields of long-term care and advocacy, who shall~~ serve on a full-time basis and shall personally, or through representatives of the office, carry out the purposes and functions of the office ~~of State Long-Term Care Ombudsman~~ in accordance with state and federal law.

(b) The ~~State Long-Term Care~~ ombudsman shall be appointed by and shall serve at the pleasure of the Secretary of Elderly

Affairs. The secretary shall appoint a person who has expertise and experience in the fields of long-term care and advocacy to serve as ombudsman. ~~No person who has a conflict of interest, or has an immediate family member who has a conflict of interest, may be involved in the designation of the ombudsman.~~

(3)(a) There is created in the office ~~of State Long-Term Care Ombudsman~~ the position of legal advocate, who shall be selected by and serve at the pleasure of the ombudsman~~,~~ and ~~who~~ shall be a member in good standing of The Florida Bar.

(b) The duties of the legal advocate shall include, but not be limited to:

1. Assisting the ombudsman in carrying out the duties of the office with respect to the abuse, neglect, or violation of rights of residents of long-term care facilities.

2. Assisting the state and local ~~ombudsman~~ councils in carrying out their responsibilities under this part.

3. Pursuing administrative, ~~Initiating and prosecuting~~ legal, and other appropriate remedies on behalf of ~~equitable actions to enforce the rights of long-term care facility~~ residents ~~as defined in this chapter~~.

4. Serving as legal counsel to the state and local ~~ombudsman~~ councils, or individual members thereof, against whom any suit or other legal action is initiated in connection with the performance of the official duties of the councils or an individual member.

Section 4. Section 400.0065, Florida Statutes, is amended to read:

400.0065 State Long-Term Care Ombudsman; duties and responsibilities~~; conflict of interest~~.--

(1) The purpose of the Office of State Long-Term Care Ombudsman shall be to:

(a) Identify, investigate, and resolve complaints made by or on behalf of residents of long-term care facilities~~,~~ relating to actions or omissions by providers or representatives of providers of long-term care services, other public or private agencies, guardians, or representative payees that may adversely affect the health, safety, welfare, or rights of the residents.

(b) Provide services that ~~to~~ assist ~~residents~~ in protecting the health, safety, welfare, and rights of ~~the~~ residents.

(c) Inform residents, their representatives, and other citizens about obtaining the services of the ~~Office of~~ State Long-Term Care Ombudsman Program and its representatives.

(d) Ensure that residents have regular and timely access to the services provided through the office and that residents and complainants receive timely responses from representatives of the office to their complaints.

(e) Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.

(f) Administer the ~~Provide administrative and technical assistance to~~ state and local ~~ombudsman~~ councils.

(g) Analyze, comment on, and monitor the development and implementation of federal, state, and local laws, rules, and

regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the state, and recommend any changes in such laws, rules, regulations, policies, and actions as the office determines to be appropriate and necessary.

(h) Provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

(2) The State Long-Term Care Ombudsman shall have the duty and authority to:

(a) Establish and coordinate ~~Assist and support the efforts of the State Long-Term Care Ombudsman Council in the establishment and coordination of~~ local ~~ombudsman~~ councils throughout the state.

(b) Perform the duties specified in state and federal law, rules, and regulations.

(c) Within the limits of appropriated federal and state funding ~~authorized and appropriated~~, employ such personnel~~,~~ ~~including staff for local ombudsman councils,~~ as are necessary to perform adequately the functions of the office and provide or contract for legal services to assist the state and local ~~ombudsman~~ councils in the performance of their duties. Staff positions established for the purpose of coordinating the activities of ~~for~~ each local ~~ombudsman~~ council and assisting its members may be ~~established as career service positions, and shall be~~ filled by the ombudsman after approval by the secretary. Notwithstanding any other provision of this part,

upon certification by the ombudsman that the staff member hired to fill any such position has completed the initial training required under s. 400.0091, such person shall be considered a representative of the State Long-Term Care Ombudsman Program for purposes of this part.

(d) Contract for services necessary to carry out the activities of the office.

(e) Apply for, receive, and accept grants, gifts, or other payments, including, but not limited to, real property, personal property, and services from a governmental entity or other public or private entity or person, and make arrangements for the use of such grants, gifts, or payments.

(f) Coordinate, to the greatest extent possible, state and local ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses and with legal assistance programs for the poor through adoption of memoranda of understanding and other means.

(g) Enter into a cooperative agreement with the Statewide Advocacy Council ~~and district human rights advocacy committees~~ for the purpose of coordinating and avoiding duplication of advocacy services provided to residents ~~of long-term care facilities~~.

(h) Enter into a cooperative agreement with the Medicaid Fraud Division as prescribed under s. 731(e)(2)(B) of the Older Americans Act.

(i) Prepare an annual report describing the activities carried out by the office, the state council, and the local councils in the year for which the report is prepared. The

ombudsman shall submit the report to the secretary at least 30 days before the convening of the regular session of the Legislature. The secretary shall in turn submit the report to the United States Assistant Secretary for Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the Secretary of Children and Family Services, and the Secretary of Health Care Administration. The report shall, at a minimum:

1. Contain and analyze data collected concerning complaints about and conditions in long-term care facilities and the disposition of such complaints.

2. Evaluate the problems experienced by residents.

3. Analyze the successes of the ombudsman program during the preceding year, including an assessment of how successfully the program has carried out its responsibilities under the Older Americans Act.

4. Provide recommendations for policy, regulatory, and statutory changes designed to solve identified problems; resolve residents' complaints; improve residents' lives and quality of care; protect residents' rights, health, safety, and welfare; and remove any barriers to the optimal operation of the State Long-Term Care Ombudsman Program.

5. Contain recommendations from the State Long-Term Care Ombudsman Council regarding program functions and activities and recommendations for policy, regulatory, and statutory changes designed to protect residents' rights, health, safety, and welfare.

6. Contain any relevant recommendations from the local councils regarding program functions and activities.

~~(3) The State Long-Term Care Ombudsman shall not:~~

~~(a) Have a direct involvement in the licensing or certification of, or an ownership or investment interest in, a long-term care facility or a provider of a long-term care service.~~

~~(b) Be employed by, or participate in the management of, a long-term care facility.~~

~~(c) Receive, or have a right to receive, directly or indirectly, remuneration, in cash or in kind, under a compensation agreement with the owner or operator of a long-term care facility.~~

~~The Department of Elderly Affairs shall adopt rules to establish procedures to identify and eliminate conflicts of interest as described in this subsection.~~

Section 5. Section 400.0066, Florida Statutes, is repealed.

Section 6. Section 400.0067, Florida Statutes, is amended to read:

400.0067 State Long-Term Care Ombudsman Council; duties; membership.--

(1) There is created within the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council.

(2) The State Long-Term Care Ombudsman Council shall:

(a) Serve as an advisory body to assist the ombudsman in reaching a consensus among local ~~ombudsman~~ councils on issues

affecting residents and impacting the optimal operation of the program ~~of statewide concern~~.

(b) Serve as an appellate body in receiving from the local ~~ombudsman~~ councils complaints not resolved at the local level. Any individual member or members of the state ~~ombudsman~~ council may enter any long-term care facility involved in an appeal, pursuant to the conditions specified in s. 400.0074(2) ~~400.0069(3)~~.

(c) Assist the ombudsman to discover, investigate, and determine the existence of abuse or neglect in any long-term care facility and work with the adult protective services program as required in ss. 415.101-415.113. ~~The Department of Elderly Affairs shall develop procedures relating to such investigations. Investigations may consist, in part, of one or more onsite administrative inspections.~~

(d) Assist the ombudsman in eliciting, receiving, responding to, and resolving complaints made by or on behalf of ~~long-term care facility~~ residents ~~and in developing procedures relating to the receipt and resolution of such complaints. The secretary shall approve all such procedures~~.

(e) Elicit and coordinate state, local, and voluntary organizational assistance for the purpose of improving the care received by residents ~~of a long-term care facility~~.

(f) Assist the ombudsman in preparing the annual report described in s. 400.0065. ~~Prepare an annual report describing the activities carried out by the ombudsman and the State Long-Term Care Ombudsman Council in the year for which the report is prepared. The State Long-Term Care Ombudsman Council shall~~

~~submit the report to the Secretary of Elderly Affairs. The secretary shall in turn submit the report to the Commissioner of the United States Administration on Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the minority leaders of the House and Senate, the chairpersons of appropriate House and Senate committees, the Secretary of Children and Family Services, and the Secretary of Health Care Administration. The report shall be submitted by the Secretary of Elderly Affairs at least 30 days before the convening of the regular session of the Legislature and shall, at a minimum:~~

~~1. Contain and analyze data collected concerning complaints about and conditions in long-term care facilities.~~

~~2. Evaluate the problems experienced by residents of long-term care facilities.~~

~~3. Contain recommendations for improving the quality of life of the residents and for protecting the health, safety, welfare, and rights of the residents.~~

~~4. Analyze the success of the ombudsman program during the preceding year and identify the barriers that prevent the optimal operation of the program. The report of the program's successes shall also address the relationship between the state long-term care ombudsman program, the Department of Elderly Affairs, the Agency for Health Care Administration, and the Department of Children and Family Services, and an assessment of how successfully the state long-term care ombudsman program has carried out its responsibilities under the Older Americans Act.~~

~~5. Provide policy and regulatory and legislative recommendations to solve identified problems; resolve residents' complaints; improve the quality of care and life of the residents; protect the health, safety, welfare, and rights of the residents; and remove the barriers to the optimal operation of the state long-term care ombudsman program.~~

~~6. Contain recommendations from the local ombudsman councils regarding program functions and activities.~~

~~7. Include a report on the activities of the legal advocate and other legal advocates acting on behalf of the local and state councils.~~

(3) ~~(a)~~ The State Long-Term Care Ombudsman Council shall be composed of one active local council member elected ~~designated~~ by each local council plus three at-large members ~~persons~~ appointed by the Governor.

(a) Each local council shall elect by majority vote a representative from among the council members to represent the interests of the local council on the state council. A local council chair may not serve as the representative of the local council on the state council.

(b)1. The secretary, after consulting ~~ombudsman, in consultation~~ with the ombudsman ~~secretary~~, shall submit to the Governor a list of persons recommended for appointment to the at-large positions on the state council. The list shall not include the name of any person who is currently ~~at least eight names of persons who are not~~ serving on a local council.

2. The Governor shall appoint three at-large members chosen from the list~~, at least one of whom must be over 60 years of age~~.

3. If the Governor does not appoint an at-large member to fill a vacant position ~~Governor's appointments are not made~~ within 60 days after ~~the ombudsman submits~~ the list is submitted, the secretary, after consulting with the ombudsman, ~~in consultation with the secretary,~~ shall appoint an at-large member to fill that vacant position ~~three members, one of whom must be over 60 years of age~~.

(c)1. All state council members shall ~~be appointed to~~ serve 3-year terms.

2. A member of the state ~~Long-Term Care Ombudsman~~ council may not serve more than two consecutive terms.

3. A local council may recommend removal of its elected representative from the state council by a majority vote. If the council votes to remove its representative, the local council chair shall immediately notify the ombudsman. The secretary shall advise the Governor of the local council's vote upon receiving notice from the ombudsman. ~~Any vacancy shall be filled in the same manner as the original appointment.~~

4. The position of any member missing three state council meetings within a 1-year period ~~consecutive regular meetings~~ without cause may ~~shall~~ be declared vacant by the ombudsman. The findings of the ombudsman regarding cause shall be final and binding.

5. Any vacancy on the state council shall be filled in the same manner as the original appointment.

(d)1. The state ~~ombudsman~~ council shall elect a chair to serve for a term of 1 year. A chair may not serve more than two consecutive terms ~~chairperson for a term of 1 year from among the members who have served for at least 1 year~~.

2. The chair ~~chairperson~~ shall select a vice chair ~~chairperson~~ from among the members. The vice chair ~~chairperson~~ shall preside over the state council in the absence of the chair ~~chairperson~~.

3. The chair may create additional executive positions as necessary to carry out the duties of the state council. Any person appointed to an executive position shall serve at the pleasure of the chair, and his or her term shall expire on the same day as the term of the chair.

4. A chair may be immediately removed from office prior to the expiration of his or her term by a vote of two-thirds of all state council members present at any meeting at which a quorum is present. If a chair is removed from office prior to the expiration of his or her term, a replacement chair shall be chosen during the same meeting in the same manner as described in this paragraph, and the term of the replacement chair shall begin immediately. The replacement chair shall serve for the remainder of the term and is eligible to serve two subsequent consecutive terms.

(e)1. The state ~~ombudsman~~ council shall meet upon the call of the chair or upon the call of the ombudsman. The council shall meet ~~chairperson,~~ at least quarterly but may meet ~~or~~ more frequently as needed.

2. A quorum shall be considered present if more than 50 percent of all active state council members are in attendance at the same meeting.

3. The state council may not vote on or otherwise make any decisions resulting in a recommendation that will directly impact the state council or any local council outside of a publicly noticed meeting at which a quorum is present.

(f) Members shall receive no compensation but shall, with approval from the ombudsman, be reimbursed for per diem and travel expenses as provided in s. 112.061.

~~(4) No officer, employee, or representative of the Office of State Long-Term Care Ombudsman or of the State Long-Term Care Ombudsman Council, nor any member of the immediate family of such officer, employee, or representative, may have a conflict of interest. The ombudsman shall adopt rules to identify and remove conflicts of interest.~~

~~(5) The Department of Elderly Affairs shall make a separate and distinct request for an appropriation for all expenses for the state and local ombudsman councils.~~

Section 7. Section 400.0069, Florida Statutes, is amended to read:

400.0069 Local long-term care ombudsman councils; duties; membership.--

(1)(a) The ombudsman shall designate local long-term care ombudsman councils to carry out the duties of the State Long-Term Care Ombudsman Program within local communities. Each local council shall function under the direction of the ombudsman.

(b) The ombudsman shall ensure that there is ~~There shall be~~ at least one local ~~long-term care ombudsman~~ council operating in each of the department's planning and service areas ~~of the Department of Elderly Affairs, which shall function under the direction of the ombudsman and the state ombudsman council~~. The ombudsman may create additional local councils as necessary to ensure that residents throughout the state have adequate access to State Long-Term Care Ombudsman Program services. The ombudsman, after approval from the secretary, shall designate the jurisdictional boundaries of each local council.

(2) The duties of the local councils ~~ombudsman council~~ are to:

(a) ~~To~~ Serve as a third-party mechanism for protecting the health, safety, welfare, and civil and human rights of residents ~~of a long-term care facility~~.

(b) ~~To~~ Discover, investigate, and determine the existence of abuse or neglect in any long-term care facility and to use the procedures provided for in ss. 415.101-415.113 when applicable. ~~Investigations may consist, in part, of one or more onsite administrative inspections.~~

(c) ~~To~~ Elicit, receive, investigate, respond to, and resolve complaints made by~~,~~ or on behalf of~~, long-term care facility~~ residents.

(d) ~~To~~ Review and, if necessary, ~~to~~ comment on~~, for their effect on the rights of long-term care facility residents,~~ all existing or proposed rules, regulations, and other governmental policies and actions relating to long-term care facilities that

may potentially have an effect on the rights, health, safety, and welfare of residents.

(e) ~~To~~ Review personal property and money accounts of ~~Medicaid~~ residents who are receiving assistance under the Medicaid program pursuant to an investigation to obtain information regarding a specific complaint or problem.

(f) Recommend that the ombudsman and the legal advocate ~~To represent the interests of residents before government agencies and to~~ seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.

(g) ~~To~~ Carry out other activities that the ombudsman determines to be appropriate.

(3) In order to carry out the duties specified in subsection (2), a member of a ~~the~~ local ~~ombudsman~~ council is authorized~~, pursuant to ss. 400.19(1) and 400.434,~~ to enter any long-term care facility without notice or first obtaining a warrant, subject to the provisions of s. 400.0074(2) ~~400.0073(5)~~.

(4) Each local ~~ombudsman~~ council shall be composed of members whose primary residence is located within the boundaries of the local council's jurisdiction.

(a) The ombudsman shall strive to ensure that each local council ~~no less than 15 members and no more than 40 members from the local planning and service area, to~~ include the following persons as members:

1. At least one medical or osteopathic physician whose practice includes or has included a substantial number of

geriatric patients and who may ~~have limited~~ practice in a long-term care facility;

2. At least one registered nurse who has geriatric experience~~, if possible~~;

3. At least one licensed pharmacist;

4. At least one registered dietitian;

5. At least six nursing home residents or representative consumer advocates for nursing home residents;

6. At least three residents of assisted living facilities or adult family-care homes or three representative consumer advocates for alternative long-term care facility residents;

7. At least one attorney; and

8. At least one professional social worker.

(b) In no case shall the medical director of a long-term care facility or an employee of the agency ~~for Health Care Administration~~, the department, the Department of Children and Family Services, or the Agency for Persons with Disabilities ~~Department of Elderly Affairs~~ serve as a member or as an ex officio member of a council. ~~Each member of the council shall certify that neither the council member nor any member of the council member's immediate family has any conflict of interest pursuant to subsection (10). Local ombudsman councils are encouraged to recruit council members who are 60 years of age or older.~~

(5)(a) Individuals wishing to join a local council shall submit an application to the ombudsman. The ombudsman shall review the individual's application and advise the secretary of his or her recommendation for approval or disapproval of the

candidate's membership on the local council. If the secretary approves of the individual's membership, the individual shall be appointed as a member of the local council.

(b) The secretary may rescind the ombudsman's approval of a member on a local council at any time. If the secretary rescinds the approval of a member on a local council, the ombudsman shall ensure that the individual is immediately removed from the local council on which he or she serves and the individual may no longer represent the State Long-Term Care Ombudsman Program until the secretary provides his or her approval.

(c) A local council may recommend the removal of one or more of its members by submitting to the ombudsman a resolution adopted by a two-thirds vote of the members of the council stating the name of the member or members recommended for removal and the reasons for the recommendation. If such a recommendation is adopted by a local council, the local council chair or district coordinator shall immediately report the council's recommendation to the ombudsman. The ombudsman shall review the recommendation of the local council and advise the secretary of his or her recommendation regarding removal of the council member or members. ~~All members shall be appointed to serve 3-year terms. Upon expiration of a term and in case of any other vacancy, the council shall select a replacement by majority vote. The ombudsman shall review the selection of the council and recommend approval or disapproval to the Governor. If no action is taken by the Governor to approve or disapprove the replacement of a member within 30 days after the ombudsman~~

~~has notified the Governor of his or her recommendation, the replacement shall be considered disapproved and the process for selection of a replacement shall be repeated.~~

(6)(a) Each ~~The~~ local ~~ombudsman~~ council shall elect a chair for a term of 1 year. There shall be no limitation on the number of terms that an approved member of a local council may serve as chair ~~from members who have served at least 1 year~~.

(b) The chair shall select a vice chair from among the members of the council. The vice chair shall preside over the council in the absence of the chair.

(c) The chair may create additional executive positions as necessary to carry out the duties of the local council. Any person appointed to an executive position shall serve at the pleasure of the chair, and his or her term shall expire on the same day as the term of the chair.

(d) A chair may be immediately removed from office prior to the expiration of his or her term by a vote of two-thirds of the members of the local council. If any chair is removed from office prior to the expiration of his or her term, a replacement chair shall be elected during the same meeting, and the term of the replacement chair shall begin immediately. The replacement chair shall serve for the remainder of the term of the person he or she replaced.

(7) Each ~~The~~ local ~~ombudsman~~ council shall meet upon the call of its ~~the~~ chair or upon the call of the ombudsman. Each local council shall meet~~,~~ at least once a month but may meet ~~or~~ more frequently if necessary ~~as needed to handle emergency situations~~.

(8) A member of a local ~~ombudsman~~ council shall receive no compensation but shall, with approval from the ombudsman, be reimbursed for travel expenses both within and outside the jurisdiction of the local council ~~county of residence~~ in accordance with the provisions of s. 112.061.

(9) The local ~~ombudsman~~ councils are authorized to call upon appropriate agencies of state government for such professional assistance as may be needed in the discharge of their duties. All state agencies shall cooperate with the local ~~ombudsman~~ councils in providing requested information and agency representation ~~representatives~~ at council meetings.

~~(10) No officer, employee, or representative of a local long-term care ombudsman council, nor any member of the immediate family of such officer, employee, or representative, may have a conflict of interest. The ombudsman shall adopt rules to identify and remove conflicts of interest.~~

Section 8. Section 400.0070, Florida Statutes, is created to read:

400.0070 Conflicts of interest.--

(1) The ombudsman shall not:

(a) Have a direct involvement in the licensing or certification of, or an ownership or investment interest in, a long-term care facility or a provider of a long-term care service.

(b) Be employed by, or participate in the management of, a long-term care facility.

(c) Receive, or have a right to receive, directly or indirectly, remuneration, in cash or in kind, under a

compensation agreement with the owner or operator of a long-term care facility.

(2) Each employee of the office, each state council member, and each local council member shall certify that he or she has no conflict of interest.

(3) The department shall define by rule:

(a) Situations that constitute a person having a conflict of interest that could materially affect the objectivity or capacity of a person to serve on an ombudsman council, or as an employee of the office, while carrying out the purposes of the State Long-Term Care Ombudsman Program as specified in this part.

(b) The procedure by which a person listed in subsection (2) shall certify that he or she has no conflict of interest.

Section 9. Section 400.0071, Florida Statutes, is amended to read:

400.0071 State Long-Term Care Ombudsman Program complaint procedures.--

~~(1)~~ The department ~~state ombudsman council~~ shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement ~~recommend to the ombudsman and the secretary~~ state and local complaint procedures. The rules shall include procedures for:

(1) Receiving complaints against a ~~nursing home or~~ long-term care facility or an ~~its~~ employee of a long-term care facility.

(2) Conducting investigations of a long-term care facility or an employee of a long-term care facility subsequent to receiving a complaint.

(3) Conducting onsite administrative assessments of long-term care facilities. ~~The procedures shall be implemented after the approval of the ombudsman and the secretary.~~

~~(2) These procedures shall be posted in full view in every nursing home or long-term care facility. Every resident or representative of a resident shall receive, upon admission to a nursing home or long-term care facility, a printed copy of the procedures of the state and the local ombudsman councils.~~

Section 10. Section 400.0073, Florida Statutes, is amended to read:

400.0073 State and local ombudsman council investigations.--

(1) A local ~~ombudsman~~ council shall investigate, within a reasonable time after a complaint is made, any complaint of a resident, a ~~or~~ representative of a resident, or any other credible source based on an action or omission by an administrator, an ~~or~~ employee, or a representative of a ~~nursing home or~~ long-term care facility which might be:

(a) Contrary to law;~~.~~

(b) Unreasonable, unfair, oppressive, or unnecessarily discriminatory, even though in accordance with law;~~.~~

(c) Based on a mistake of fact;~~.~~

(d) Based on improper or irrelevant grounds;~~.~~

(e) Unaccompanied by an adequate statement of reasons;~~.~~

(f) Performed in an inefficient manner; or~~.~~

(g) Otherwise adversely affecting the health, safety, welfare, or rights of a resident ~~erroneous~~.

(2) In an investigation, both the state and local ~~ombudsman~~ councils have the authority to hold public hearings.

(3) Subsequent to an appeal from a local ~~ombudsman~~ council, the state ~~ombudsman~~ council may investigate any complaint received by the local council involving a ~~nursing home or~~ long-term care facility or a resident.

(4) If the ombudsman or any state or local council member is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the office, the state council, or the local council in the performance of official duties as described in s. 400.0083(1) and to have committed a violation of this part. The ombudsman shall report a facility's refusal to allow entry to the agency, and the agency shall record the report and take it into consideration when determining actions allowable under s. 400.102, s. 400.121, s. 400.414, s. 400.419, s. 400.6194, or s. 400.6196. ~~In addition to any specific investigation made pursuant to a complaint, the local ombudsman council shall conduct, at least annually, an investigation, which shall consist, in part, of an onsite administrative inspection, of each nursing home or long-term care facility within its jurisdiction. This inspection shall focus on the rights, health, safety, and welfare of the residents.~~

~~(5) Any onsite administrative inspection conducted by an ombudsman council shall be subject to the following:~~

~~(a) All inspections shall be at times and for durations necessary to produce the information required to carry out the duties of the council.~~

~~(b) No advance notice of an inspection shall be provided to any nursing home or long-term care facility, except that notice of followup inspections on specific problems may be provided.~~

~~(c) Inspections shall be conducted in a manner which will impose no unreasonable burden on nursing homes or long-term care facilities, consistent with the underlying purposes of this part. Unnecessary duplication of efforts among council members or the councils shall be reduced to the extent possible.~~

~~(d) Any ombudsman council member physically present for the inspection shall identify himself or herself and the statutory authority for his or her inspection of the facility.~~

~~(e) Inspections may not unreasonably interfere with the programs and activities of clients within the facility. Ombudsman council members shall respect the rights of residents.~~

~~(f) All inspections shall be limited to compliance with parts II, III, and VII of this chapter and 42 U.S.C. ss. 1396(a) et seq., and any rules or regulations promulgated pursuant to such laws.~~

~~(g) No ombudsman council member shall enter a single-family residential unit within a long-term care facility without the permission of the resident or the representative of the resident.~~

~~(h) Any inspection resulting from a specific complaint made to an ombudsman council concerning a facility shall be conducted within a reasonable time after the complaint is made.~~

~~(6) An inspection may not be accomplished by forcible entry. Refusal of a long-term care facility to allow entry of any ombudsman council member constitutes a violation of part II, part III, or part VII of this chapter.~~

Section 11. Section 400.0074, Florida Statutes, is created to read:

400.0074 Local ombudsman council onsite administrative assessments.--

(1) In addition to any specific investigation conducted pursuant to a complaint, the local council shall conduct, at least annually, an onsite administrative assessment of each nursing home, assisted living facility, and adult family-care home within its jurisdiction. This administrative assessment shall focus on factors affecting the rights, health, safety, and welfare of the residents. Each local council is encouraged to conduct a similar onsite administrative assessment of each additional long-term care facility within its jurisdiction.

(2) An onsite administrative assessment conducted by a local council shall be subject to the following conditions:

(a) To the extent possible and reasonable, the administrative assessments shall not duplicate the efforts of the agency surveys and inspections conducted under parts II, III, and VII of this chapter.

(b) An administrative assessment shall be conducted at a time and for a duration necessary to produce the information required to carry out the duties of the local council.

(c) Advance notice of an administrative assessment may not be provided to a long-term care facility, except that notice of followup assessments on specific problems may be provided.

(d) A local council member physically present for the administrative assessment shall identify himself or herself and cite the specific statutory authority for his or her assessment of the facility.

(e) An administrative assessment may not unreasonably interfere with the programs and activities of residents.

(f) A local council member may not enter a single-family residential unit within a long-term care facility during an administrative assessment without the permission of the resident or the representative of the resident.

(g) An administrative assessment shall be conducted in a manner that will impose no unreasonable burden on the long-term care facility.

(3) Regardless of jurisdiction, the ombudsman may authorize a state or local council member to assist another local council to perform the administrative assessments described in this section.

(4) An onsite administrative assessment may not be accomplished by forcible entry. However, if the ombudsman or a state or local council member is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the

office, the state council, or the local council in the performance of official duties as described in s. 400.0083(1) and to have committed a violation of this part. The ombudsman shall report the refusal by a facility to allow entry to the agency, and the agency shall record the report and take it into consideration when determining actions allowable under s. 400.102, s. 400.121, s. 400.414, s. 400.419, s. 400.6194, or s. 400.6196.

Section 12. Section 400.0075, Florida Statutes, is amended to read:

400.0075 Complaint notification and resolution procedures.--

(1)(a) Any complaint or~~, including any~~ problem verified ~~identified~~ by an ombudsman council as a result of an investigation or onsite administrative assessment, which complaint or problem is determined to require~~, deemed valid and requiring~~ remedial action by the local ~~ombudsman~~ council, shall be identified and brought to the attention of the long-term care facility administrator in writing. Upon receipt of such document, the administrator, ~~in concurrence~~ with the concurrence of the local ~~ombudsman~~ council chair, shall establish target dates for taking appropriate remedial action. If, by the target date, the remedial action is not completed or forthcoming, the local ~~ombudsman~~ council chair may, after obtaining approval from the ombudsman and a majority of the members of the local council:

1. ~~(a)~~ Extend the target date if the chair ~~council~~ has reason to believe such action would facilitate the resolution of the complaint.

2. ~~(b)~~ In accordance with s. 400.0077, publicize the complaint, the recommendations of the council, and the response of the long-term care facility.

3. ~~(c)~~ Refer the complaint to the state ~~ombudsman~~ council.

(b) If the local council chair believes that the health, safety, welfare, or rights of the resident are in imminent danger, the chair shall notify the ombudsman or legal advocate, who, after verifying that such imminent danger exists, shall ~~local long-term care ombudsman council may~~ seek immediate legal or administrative remedies to protect the resident.

(c) If the ombudsman has reason to believe that the long-term care facility or an employee of the facility has committed a criminal act, the ombudsman shall provide the local law enforcement agency with the relevant information to initiate an investigation of the case.

(2)(a) Upon referral from a ~~the~~ local ~~ombudsman~~ council, the state ~~ombudsman~~ council shall assume the responsibility for the disposition of the complaint. If a long-term care facility fails to take action on a complaint ~~found valid~~ by the state ~~ombudsman~~ council, the state council may, after obtaining approval from the ombudsman and a majority of the state council members:

1. ~~(a)~~ In accordance with s. 400.0077, publicize the complaint, the recommendations of the local or state council, and the response of the long-term care facility.

2. ~~(b)~~ Recommend to the department and the agency a series of facility reviews pursuant to s. 400.19~~(4)~~, s. 400.434, or s. 400.619 to ensure ~~assure~~ correction and nonrecurrence of conditions that give rise to complaints against a long-term care facility.

~~(c) Recommend to the agency changes in rules for inspecting and licensing or certifying long-term care facilities, and recommend to the Agency for Health Care Administration changes in rules for licensing and regulating long-term care facilities.~~

~~(d) Refer the complaint to the state attorney for prosecution if there is reason to believe the long-term care facility or its employee is guilty of a criminal act.~~

3. ~~(e)~~ Recommend to the department and the agency ~~for Health Care Administration~~ that the long-term care facility no longer receive payments under any ~~the~~ state ~~Medical~~ assistance program, including ~~(~~Medicaid~~)~~.

4. ~~(f)~~ Recommend to ~~that~~ the department and the agency that ~~initiate~~ procedures be initiated for revocation of the long-term care facility's license in accordance with chapter 120.

~~(g) Seek legal, administrative, or other remedies to protect the health, safety, welfare, or rights of the resident.~~

(b) If the state council chair believes that the health, safety, welfare, or rights of the resident are in imminent danger, the chair shall notify the ombudsman or legal advocate, who, after verifying that such imminent danger exists, ~~State Long Term Care Ombudsman Council~~ shall seek immediate legal or administrative remedies to protect the resident.

(c) If the ombudsman has reason to believe that the long-term care facility or an employee of the facility has committed a criminal act, the ombudsman shall provide local law enforcement with the relevant information to initiate an investigation of the case.

~~(3) The state ombudsman council shall provide, as part of its annual report required pursuant to s. 400.0067(2)(f), information relating to the disposition of all complaints to the Department of Elderly Affairs.~~

Section 13. Section 400.0078, Florida Statutes, is amended to read:

400.0078 Citizen access to State Long-Term Care Ombudsman Program services ~~Statewide toll-free telephone number~~.--

(1) The office ~~of State Long-Term Care Ombudsman~~ shall establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents ~~nursing facilities~~.

(2) Every resident or representative of a resident shall receive, upon admission to a long-term care facility, information regarding the purpose of the State Long-Term Care Ombudsman Program, the statewide toll-free telephone number for receiving complaints, and other relevant information regarding how to contact the program. Residents or their representatives must be furnished additional copies of this information upon request.

Section 14. Section 400.0079, Florida Statutes, is amended to read:

400.0079 Immunity.--

(1) Any person making a complaint pursuant to this part ~~act~~ who does so in good faith shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed as a direct or indirect result of making the complaint.

(2) The ombudsman or any person authorized by the ombudsman to act ~~acting~~ on behalf of the office, as well as all members of ~~State Long-Term Care Ombudsman or~~ the state and ~~or a~~ local councils, ~~long-term care ombudsman council~~ shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed~~,~~ during the good faith performance of official duties.

Section 15. Section 400.0081, Florida Statutes, is amended to read:

400.0081 Access to facilities, residents, and records.--

(1) A long-term care facility shall provide the office ~~of State Long-Term Care Ombudsman~~, the state ~~Long-Term Care Ombudsman~~ council and its members, and the local councils and their members ~~long-term care ombudsman councils, or their representatives, shall have~~ access to:

(a) Any portion of the long-term care facility and any resident as necessary to investigate or resolve a complaint ~~facilities and residents~~.

(b) Medical and social records of a resident for review as necessary to investigate or resolve a complaint, if:

1. The office has the permission of the resident or the legal representative of the resident; or

2. The resident is unable to consent to the review and has no legal representative.

(c) Medical and social records of the resident as necessary to investigate or resolve a complaint, if:

1. A legal representative ~~guardian~~ of the resident refuses to give permission; ~~.~~

2. The office has reasonable cause to believe that the representative ~~guardian~~ is not acting in the best interests of the resident; and ~~.~~

3. The state or local council member ~~representative~~ obtains the approval of the ombudsman.

(d) The administrative records, policies, and documents to which ~~the~~ residents ~~,~~ or the general public ~~,~~ have access.

(e) Upon request, copies of all licensing and certification records maintained by the state with respect to a long-term care facility.

~~(2) Notwithstanding paragraph (1)(b), if, pursuant to a complaint investigation by the state ombudsman council or a local ombudsman council, the legal representative of the resident refuses to give permission for the release of the resident's records, and if the Office of State Long-Term Care Ombudsman has reasonable cause to find that the legal representative is not acting in the best interests of the resident, the medical and social records of the resident must be made available to the state or local council as is necessary for the members of the council to investigate the complaint.~~

(2) ~~(3)~~ The department ~~of Elderly Affairs~~, in consultation with the ombudsman and the state ~~Long-Term Care Ombudsman~~

council, may ~~shall~~ adopt rules to establish procedures to ensure access to facilities, residents, and records as described in this section.

Section 16. Section 400.0083, Florida Statutes, is amended to read:

400.0083 Interference; retaliation; penalties.--

(1) It shall be unlawful for any person, long-term care facility, or other entity to willfully interfere with a representative of the office ~~of State Long-Term Care Ombudsman~~, the state ~~Long-Term Care Ombudsman~~ council, or a local ~~long-term care ombudsman~~ council in the performance of official duties.

(2) It shall be unlawful for any person, long-term care facility, or other entity to knowingly or willfully take action or retaliate against any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of the office ~~of State Long-Term Care Ombudsman~~, the state ~~Long-Term Care Ombudsman~~ council, or a local ~~long-term care ombudsman~~ council.

(3) ~~(a)~~ Any person, long-term care facility, or other entity that ~~who~~ violates this section:

(a) Shall be liable for damages and equitable relief as determined by law.

(b) ~~Any person, long-term care facility, or other entity who violates this section~~ Commits a misdemeanor of the second degree, punishable as provided in s. 775.083.

Section 17. Section 400.0085, Florida Statutes, is repealed.

Section 18. Section 400.0087, Florida Statutes, is amended to read:

400.0087 Department ~~Agency~~ oversight; funding.--

(1) The department shall meet the costs associated with the State Long-Term Care Ombudsman Program from funds appropriated to it.

(a) The department shall include the costs associated with support of the State Long-Term Care Ombudsman Program when developing its budget requests for consideration by the Governor and submittal to the Legislature.

(b) The department may divert from the federal ombudsman appropriation an amount equal to the department's administrative cost ratio to cover the costs associated with administering the program. The remaining allotment from the Older Americans Act program shall be expended on direct ombudsman activities.

(2) ~~(1)~~ The department ~~of Elderly Affairs~~ shall monitor the office, the state council, and the local ~~ombudsman~~ councils to ensure that each is ~~responsible for~~ carrying out the duties delegated to it by state ~~by s. 400.0069~~ and federal law. ~~The department, in consultation with the ombudsman, shall adopt rules to establish the policies and procedures for the monitoring of local ombudsman councils.~~

(3) ~~(2)~~ The department is responsible for ensuring that the office:

(a) Has the objectivity and independence required to qualify it for funding under the federal Older Americans Act.

(b) ~~of State Long-Term Care Ombudsman~~ Provides information to public and private agencies, legislators, and others.~~,~~

(c) Provides appropriate training to representatives of the office or of the state or local ~~long-term care ombudsman~~ councils.~~; and~~

(d) Coordinates ombudsman services with the Advocacy Center for Persons with Disabilities and with providers of legal services to residents of long-term care facilities in compliance with state and federal laws.

(4)~~(3)~~ The department ~~of Elderly Affairs is the designated state unit on aging for purposes of complying with the federal Older Americans Act. The Department of Elderly Affairs shall ensure that the ombudsman program has the objectivity and independence required to qualify it for funding under the federal Older Americans Act, and shall carry out the long-term care ombudsman program through the Office of State Long-Term Care Ombudsman. The Department of Elderly Affairs~~ shall also:

(a) Receive and disburse state and federal funds for purposes that the ~~state~~ ombudsman ~~council~~ has formulated in accordance with the Older Americans Act.

(b) Whenever necessary, act as liaison between agencies and branches of the federal and state governments and the State Long-Term Care Ombudsman Program ~~representatives, the staffs of the state and local ombudsman councils, and members of the state and local ombudsman councils~~.

Section 19. Section 400.0089, Florida Statutes, is amended to read:

400.0089 Complaint data ~~Agency~~ reports.--The office ~~Department of Elderly Affairs~~ shall maintain a statewide uniform reporting system to collect and analyze data relating to

complaints and conditions in long-term care facilities and to residents~~,~~ for the purpose of identifying and resolving significant problems. ~~The department and the State Long-Term Care Ombudsman Council shall submit such data as part of its annual report required pursuant to s. 400.0067(2)(f) to the Agency for Health Care Administration, the Department of Children and Family Services, the Florida Statewide Advocacy Council, the Advocacy Center for Persons with Disabilities, the Commissioner for the United States Administration on Aging, the National Ombudsman Resource Center, and any other state or federal entities that the ombudsman determines appropriate.~~ The office ~~State Long-Term Care Ombudsman Council~~ shall publish quarterly and make readily available information pertaining to the number and types of complaints received by the State Long-Term Care Ombudsman Program and shall include such information in the annual report required under s. 400.0065.

Section 20. Section 400.0091, Florida Statutes, is amended to read:

400.0091 Training.--The ombudsman shall ensure that ~~provide~~ appropriate training is provided to all employees of the office ~~of State Long-Term Care Ombudsman~~ and to the members of the state and local ~~long-term care ombudsman~~ councils~~, including all unpaid volunteers~~.

(1) All state and local council members ~~volunteers~~ and ~~appropriate~~ employees of the office shall ~~of State Long-Term Care Ombudsman must~~ be given a minimum of 20 hours of training upon employment with the office or approval ~~enrollment~~ as a

state or local council member ~~volunteer~~ and 10 hours of continuing education annually thereafter.

(2) The ombudsman shall approve the curriculum for the initial and continuing education training, which must ~~cover~~, at a minimum, address:

(a) Resident confidentiality.

(b) Guardianships and powers of attorney.~~,~~

(c) Medication administration.~~,~~

(d) Care and medication of residents with dementia and Alzheimer's disease.~~,~~

(e) Accounting for residents' funds.~~,~~

(f) Discharge rights and responsibilities.~~, and~~

(g) Cultural sensitivity.

(h) Any other topic recommended by the secretary.

(3) No employee, officer, or representative of the office or of the state or local ~~long-term care ombudsman~~ councils, other than the ombudsman, may hold himself or herself out as a representative of the State Long-Term Care Ombudsman Program or conduct ~~carry out~~ any authorized program ~~ombudsman~~ duty described in this part ~~or responsibility~~ unless the person has received the training required by this section and has been certified ~~approved~~ by the ombudsman as qualified to carry out ombudsman activities on behalf of the office or the state or local ~~long-term care ombudsman~~ councils.

Section 21. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1157 CS Dental Charting
SPONSOR(S): Mayfield
TIED BILLS: **IDEN./SIM. BILLS:** SB 2178

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	10 Y, 0 N, w/CS	Hamrick	Mitchell
2) Health Care Appropriations Committee	14 Y, 0 N	Money	Massengale
3) Health & Families Council		Hamrick LH	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 1157 CS expands the scope of practice for dental hygienists to enable them to perform dental charting without supervision by a dentist in locations such as public educational institutions, nursing homes, community health centers, county health departments, and health fairs with certain limitations. Dental charting is the recording of visual observations of clinical conditions of the mouth, such as missing teeth and restorations.

The bill does not appear to have a fiscal impact on state or local governments.

The bill will take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government and promote personal responsibility—The bill allows dental hygienists to perform dental charting without supervision by a dentist in locations such as public educational institutions, nursing homes, community health centers, and health fairs.

B. EFFECT OF PROPOSED CHANGES:

The bill expands the scope of practice of dental hygienists by allowing them to perform the task of dental charting without supervision of a dentist. The bill provides that dental charting is the recording of visual observations of clinical conditions of the mouth. Visual observations are done without the use of such diagnostic tools as x-rays or laboratory tests. The bill provides that a dental hygienist may only use instruments that are necessary to look at missing teeth, restorations, suspicious areas, and periodontal pockets. The bill requires that a dental hygienist receive medical clearance, from a physician or a dentist, prior to using a periodontal probe while performing dental charting. A periodontal probe is a measuring tool that is used in the diagnosis of periodontal disease.

The bill provides that dental charting may be performed in public and private educational institutions of the state and federal government, nursing homes, assisted living and long-term care facilities, community health centers, county health departments, health fairs, and mobile dental or health units. Dental charting may be performed for public health epidemiological surveys.

A person who receives dental charting must receive and acknowledge a written disclosure form. The disclosure form must state that the purpose of the dental charting is to collect data for use by a dentist at a prompt subsequent examination and that the diagnosis of cavities, soft tissue disease, oral cancer, and certain other conditions may only be done by a dentist during a comprehensive examination.

The bill requires that the Board of Dentistry approve the content of the disclosure and dental charting forms. Both forms must emphasize the limitation of dental charting and encourage a complete dental examination to assess a person's overall oral health.

The bill places restrictions on direct reimbursement and patient referrals which require compliance with anti-kickback and patient brokering laws. The bill also stipulates that performing dental charting does not create a patient of record or a medical record.

PRESENT SITUATION

According to the Children's Dental Health Project (CDHP), tooth decay is the single most common chronic disease of childhood. Without access to regular preventative dental services, dental care for many children is postponed until symptoms become so acute that care is sought in hospital emergency departments.[1] According to the CDHP, more than 51 million school hours are lost each year to dental-related illness and 25 percent of children living in poverty have not seen a dentist prior to entering kindergarten.[2]

A report by the Surgeon General found that people 55 to 74 years of age have higher rates of periodontal disease and also have an increasing amount of tooth decay compared to younger adults.

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[1] Chidren's Dental Health Project. 2005. A Policy Brief: Cost Effectiveness of Preventative Dental Services.
[2] Chidren's Dental Health Project. 2002. Children's Dental Health Needs and School-Based Services: A Fact Sheet.

The elderly's use of dental care can be substantially influenced by financial barriers and other nondental health concerns.[3]

Dental Hygienists Current Scope of Practice

Section 466.024, Florida Statutes, provides that dental hygienists may remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and shallow grooves or depressions of the gums. They may use metal scalers to perform deep teeth cleaning which involves the removal of hard deposits, below the gumline. They may also use a spoon-shaped instrument called curettage, to scrape tissue from a cavity.

Dental hygienists may expose dental X-ray films, apply topical preventive or prophylactic agents, and perform tasks delegated by a supervising dentist.

Currently, a dental hygienist may work in an office of a licensed dentist, in public health programs and institutions of the Department of Children and Family Services, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist.

A dental hygienist may work in other settings, if a patient presents a valid prescription from a dentist that is not older than two years. Such settings include:

- Licensed public and private health facilities;
- Other public institutions of the state and federal government;
- Public and private educational institutions; and,
- The home of a non-ambulatory patient.

In this situation, the dentist issuing a prescription for dental hygiene care remains responsible for the care the patient.

Dental hygienists may, without supervision, provide educational programs, faculty or staff training programs, authorized fluoride rinse programs, and other services which do not involve diagnosis or treatment of dental conditions and which services are approved by the Board of Dentistry.

C. SECTION DIRECTORY:

Section 1. Amends s. 466.023, F. S., to provide that a dental hygienist may perform dental charting without supervision.

Section 2. Creates s. 466.0235, F. S., to provide a definition of dental charting; locations where dental charting may occur; a written disclosure that must be received and acknowledged when dental charting occurs; provide a restriction on periodontal probe use in dental charting; require board approval of the content of the disclosure and dental charting form; place restrictions on direct reimbursement, and patient referrals; and establish that the use of a dental charting form does not constitute the creation of a patient of record or a medical record.

Section 3. Provides that the bill will take effect on July 1, 2006.

[3] The United States Department of Health and Human Services. 2000. Oral health in America: a report of the Surgeon General.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Dental charting performed by dental hygienists may provide access to needed dental services, specifically preventative oral health screenings, by low income children and adults. The screenings may encourage individuals to have a comprehensive dental examination done. Failure to prevent dental problems may have adverse long-term effects, which may be costly.

D. FISCAL COMMENTS:

According to the Department of Health, there may be a minimal fiscal impact for rule promulgation, which can be covered with existing resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides that the board must approve the content of a disclosure and a dental charting form. According to the Department of Health, the bill does not explicitly require the board to engage in rulemaking. Due to the lack of clarity and implication, more specific rule-making authorization would be beneficial.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill amends sections 466.023 and 466.0235, Florida Statutes. Senate Bill 2178 amends s. 466.0241, F. S.

The bill provides on lines 42-43, that a dental hygienist may perform dental charting in "...public and private educational institutions of the state and federal government." This is problematic since there are not any "private educational institutions of the state and federal government."

It would be beneficial to provide rule-making authority to the Board of Dentistry to approve the content of the disclosure and dental charting forms.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 22, 2006, the Health Care Regulation Committee adopted 3 amendments offered by the bill's sponsor. The Committee Substitute differs from the original bill as filed in that it:

- Added language that limits the use of a periodontal probe while performing dental charting.
- Allows a dental hygienist to perform dental charting for public health epidemiological surveys and at county health departments.
- Removes the requirement that a person receiving dental charting must review and sign a disclosure form. The bill now states that a person must receive and acknowledge a disclosure form.

The bill, as amended, was reported favorably as a committee substitute. This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to dental charting; amending s. 466.023, F.S.; expanding the scope and area of practice of dental hygienists to include dental charting; creating s. 466.0235, F.S.; providing for regulation of dental charting; providing a definition; authorizing dental hygienists to perform dental charting under certain conditions; regulating the use and content of disclosure and charting forms; requiring the Board of Dentistry to approve disclosure and charting forms; limiting the applicability of dental charting; providing restrictions on periodontal probe use in dental charting; providing restrictions on dental charting reimbursement, referrals made in conjunction with the provision of dental charting services, and the provision of dental charting by a dental hygienist without supervision; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (5) of section 466.023, Florida Statutes, is renumbered as subsection (6) and a new subsection (5) is added to that section to read:

466.023 Dental hygienists; scope and area of practice.--

(5) Dental hygienists may, without supervision, perform dental charting as provided in s. 466.0235.

Section 2. Section 466.0235, Florida Statutes, is created to read:

466.0235 Dental charting.--

(1) For purposes of this section, the term "dental charting" means a recording of visual observations of clinical conditions of the oral cavity without the use of X rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets.

(2) A dental hygienist may, without supervision and within the lawful scope of his or her duties as authorized by law, perform dental charting of hard and soft tissues in public and private educational institutions of the state and Federal Government, nursing homes, assisted living and long-term care facilities, community health centers, county health departments, mobile dental or health units, and epidemiological surveys for public health. A dental hygienist may also perform dental charting on a volunteer basis at health fairs.

(3) Each person who receives a dental charting pursuant to this section, or the parent or legal guardian of the person, shall receive and acknowledge a written disclosure form before

receiving the dental charting procedure that states that the purpose of the dental charting is to collect data for use by a dentist at a prompt subsequent examination. The disclosure form shall also emphasize that diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions can only be completed by a dentist in the context of delivering a comprehensive dental examination.

(4) The board shall approve the content of charting and disclosure forms to be used under this section. Both forms shall emphasize the inherent limitations of dental charting and encourage complete examination by a dentist in rendering a professional diagnosis of the patient's overall oral health needs.

(5) Dental charting performed under this section is not a substitute for a comprehensive dental examination.

(6) Medical clearance by a physician or dentist is required before a periodontal probe may be used on a person who receives a dental charting.

(7) Nothing in this section shall be construed to permit direct reimbursement for dental charting performed under this section by Medicaid, health insurers, health maintenance organizations, prepaid dental plans, or other third-party payors beyond what is otherwise allowable by law.

(8) All referrals made in conjunction with the provision of dental charting services under this section shall be in strict conformance with federal and state patient referral, anti-kickback, and patient brokering laws.

(9) A dental hygienist performing dental charting without supervision shall not be deemed to have created either a patient of record or a medical record.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1293 CS Medical Malpractice Insurance
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 2160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 2 N, w/CS	Bell	Mitchell
2) Health & Families Council		Bell AJB	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 1293 with CS creates ss. 766.401-766.406, F.S., to provide incentives for statutory teaching hospitals to implement hospital-wide patient safety programs and to address the issue of medical malpractice.

The bill specifies the six statutory teaching hospitals in the state as eligible to participate in the Patient Safety and Provider Liability Act. The hospitals targeted in the bill are: Jackson Memorial Hospital, Tampa General Hospital, Shands at the University of Florida, Shands Jacksonville, Orlando Regional Medical Center, and Mount Sinai Medical Center.

The bill encourages and provides incentives for the eligible hospitals to create a patient safety plan that includes an array of patient safety protection measures that are described in s. 766.403, F.S, created in the bill. Some of the incentives include participation in the Florida Patient Safety Corporation's "near miss" reporting system and implementation of a simulation-based program for skills assessment, training, and retraining of facility staff. Patient safety plans would be reviewed and certified by the Agency for Health Care Administration.

A hospital that obtains certification from AHCA would qualify for a $500,000 limit on noneconomic damages in medical malpractice actions, and periodic payments of economic damages.

The bill also clarifies that *any* hospital may extend insurance or self-insurance coverage to members of its medical staff.

It is unclear how many eligible hospitals would submit a patient safety plan to be certified by the Agency for Health Care Administration (AHCA). AHCA may incur a cost to certify patient safety plans created in the bill. AHCA did not provide the Health Care Regulation Committee with an estimated fiscal impact.

The effective date of the bill is upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill creates parameters for patient safety plans. Eligible hospitals would be required to get their plans certified by the Agency for Health Care Administration (AHCA). Eligible hospitals with certified patient safety plans would qualify for a $500,000 cap on noneconomic damages arising from medical malpractice and periodic payments of economic damages.

Empower Families – The patient safety plan requirements are likely to improve the quality of care for patients in certified patient safety facilities.

B. EFFECT OF PROPOSED CHANGES:

Overview

The bill creates ss. 766.401-766.406, F.S., to provide incentives for statutory teaching hospitals to implement hospital-wide patient safety programs and to address the issue of medical malpractice.

The bill creates an unnumbered section to designate a short title and provide legislative findings. The short title is, "Patient Safety and Provider Liability Act."

The bill specifies the six statutory teaching hospitals in the state as eligible to participate in the Patient Safety and Provider Liability Act. The hospitals are: Jackson Memorial Hospital, Tampa General Hospital, Shands at the University of Florida, Shands Jacksonville, Orlando Regional Medical Center, and Mount Sinai Medical Center.

The bill encourages and provides incentives for the eligible hospitals to create a patient safety plan that includes an array of patient safety protection measures that are described in s. 766.403, F.S, created in the bill.

Patient safety plans are reviewed and certified by the Agency for Health Care Administration (AHCA). Plans must satisfy all the requirements created in ss. 766.401-766.405, F.S. The patient safety provisions include: participation in the Florida Patient Safety Corporation's "near miss" reporting system, implementation of an early intervention program that provides additional skill training, and a simulation program for skills assessment, training, and staff retraining.

An eligible hospital that obtains certification from AHCA that its patient safety plan meets the requirements qualifies for a $500,000 limit on noneconomic damages in medical malpractice actions and may make periodic payments of economic damages.

The bill amends s. 766.110, F.S. to clarify that any hospital may extend insurance or self-insurance coverage to members of its medical staff.

The effective date of the bill is upon becoming law.

Patient Safety Certification

The bill provides incentives for statutory teaching hospitals to seek designation as a certified patient safety facility by submitting a petition to the Agency for Health Care Administration (AHCA). The petition would seek an AHCA order approving the facility's patient safety plan. The order would remain in effect until revoked by AHCA. The bill requires hospitals with certified patient safety plans to submit an annual report to AHCA.

Patient Safety Requirements

A patient safety plan must include several comprehensive patient safety measures and procedures. In order for a statutory teaching hospital to qualify for the $500,000 cap on noneconomic damages and periodic payments of economic damages, an eligible hospital's patient safety plans must:

- Have in place a process for coordinating the quality control, risk management, and patient-relations functions of the facility and for reporting to the facility's governing board at least quarterly regarding such efforts;
- Establish within the facility a system for reporting near misses and agree to submit any information collected to the Florida Patient Safety Corporation (FPSC);
- Design and make available to facility staff a patient-safety curriculum that provides lectures and web-based training on recognized patient-safety principles. It may include training in communication skills, team-performance assessment and training, risk-prevention strategies, and best practice and evidenced based medicine. The licensed facility shall report annually to AHCA;
- Implement a program to identify health care providers on the facility's staff who may be eligible for an early intervention program that provides additional skills for assessment and training and offer such training to the staff on a voluntary and confidential basis with established mechanisms to assess program performance and results;
- Implement a simulation-based program for skills assessment, training, and retraining of a facility's staff in those tasks and activities that AHCA identifies by rule;
- Designate a patient advocate who coordinates with members of the medical staff and the facility's chief medical officer regarding the disclosure of adverse medical incidents to patients. In addition, the patient advocate shall establish an advisory panel, consisting of providers, patients and their families, and other health care consumers or consumer groups to review general patient-safety concerns and other issues related to relations among and between patients and providers and to identify areas where additional education and program development may be appropriate;
- Establish procedures to biennially review the facility's patient-safety program and its compliance with s. 766.402, F.S. Such review shall be conducted by an independent patient-safety organization as defined by s. 766.1016(1), F.S., or other professional organization approved by AHCA. The organization performing the review shall prepare a written report that contains detailed findings and recommendations. The report shall be forwarded to the facility's risk manager or patient-safety officer, who may make written comments in response. The report and any written comments shall be presented to the governing board of the licensed facility. A copy of the report and any of the facility's responses to the findings and recommendations shall be provided to AHCA within 60 days after the date that the governing board reviewed the report.; and
- Establish a system for trending and tracking of quality patient-safety indicators that AHCA may identify by rule, and a method for review of the data at least semiannually by the facility's patient-safety committee.

Limits on Nonecomonic Damages

In exchange for the patient safety provisions included in the statutory teaching hospital's patient safety plans, eligible hospitals will have a $500,000 limit on noneconomic damages in medical malpractice actions, regardless of number of claimants, number of claims, or theory of liability, including vicarious liability, arising from the same nucleus of operative fact.

Periodic Payments of Economic Damages

Another benefit of compliance with the patient safety plan requirements, is that teaching hospitals will be permitted to make periodic payment of future economic damages. This will provide for the payment of damages over time, rather than lump-sum payments.

The bill requires periodic payments to be paid through an annuity or a reversionary trust. The annuity underwriting company must have a rating of "A" or higher by A.M. Best Company.

Legislative Findings

The bill provides legislative findings and intent related to medical education in Florida, patient safety, medical malpractice, and statutory teaching hospitals. The bill makes the following legislative findings:

- This state is in the midst of a prolonged medical malpractice insurance crisis that has serious adverse effects on patients, practitioners, licensed health care facilities, and all residents of this state.
- Hospitals are central components of the modern health care delivery system.
- The medical malpractice insurance crisis in this state can be alleviated through the adoption of innovative approaches for patient safety in teaching hospitals, which can lead to a reduction in medical errors coupled with a limitation on noneconomic damages that can be awarded against a teaching hospital that implements such innovative approaches.
- Statutory incentives are necessary to facilitate innovative approaches for patient safety in hospitals and that such incentives and patient-safety measures will benefit all persons seeking health care services in this state.
- Coupling patient safety measures with a limitation on provider liability in teaching hospitals will lead to a reduction in the frequency and severity of incidents of medical malpractice in hospitals.
- A reduction in the frequency and severity of incidents of medical malpractice in hospitals will reduce attorney's fees and other expenses inherent in the medical liability system.
- There is no alternative method that addresses the overwhelming public necessity to implement patient-safety measures and limit provider liability.
- Making high-quality health care available to the residents of this state is an overwhelming public necessity.
- Medical education in this state is an overwhelming public necessity.
- Statutory teaching hospitals are essential for high-quality medical care and medical education in this state.
- The critical mission of statutory teaching hospitals is severely undermined by the ongoing medical malpractice crisis.
- Teaching hospitals are appropriate health care facilities for the implementation of innovative approaches to enhancing patient safety and limiting provider liability.
- There is an overwhelming public necessity to impose reasonable limitations on actions for medical malpractice against teaching hospitals in furtherance of the critical public interest in promoting access to high-quality medical care, medical education, and innovative approaches to patient safety and provider liability.
- There is an overwhelming public necessity for teaching hospitals to implement innovative measures for patient safety and limit provider liability in order to generate empirical data for state policymakers concerning the effectiveness of these measures. Such data may lead to broader application of these measures in a wider array of hospitals after a reasonable period of evaluation and review.
- There is an overwhelming public necessity to promote the academic mission of teaching hospitals. Furthermore, the Legislature finds that the academic mission of these medical facilities is materially enhanced by statutory authority for the implementation of innovative approaches to promoting patient safety and limiting provider liability. Such approaches can be carefully studied and learned by medical students, medical school faculty, and affiliated physicians in appropriate clinical settings, thereby enlarging the body of knowledge concerning patient safety and provider liability which is essential for advancement of patient safety and reduction of expenses inherent in the medical malpractice insurance crisis in this state.

CURRENT SITUATION

Patient Safety Requirements

Currently hospitals are required to have a number of patient safety provisions. Section 395.1012, F.S. requires all hospitals to adopt a patient safety plan, a patient safety officer, and a patient safety committee. The various structures hospitals have developed to meet this requirement vary in composition and quality.

As part of the health care practitioner general licensing provisions in s. 456.013, F.S., health care practitioners are required to take a 2-hour course relating to prevention of medical errors as part of the licensure and biennial renewal process.

As part of licensure, hospitals are required in s. 395.0197, F.S., to have an internal risk management program. The internal risk management program requires hospitals and physicians to disclose adverse incidents to patients. The Agency for Health Care Administration (AHCA) collects data on certain adverse incidents. These reports are known as "code 15" reports. Hospitals must report to AHCA within 15 days:

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- The performance of a wrong surgical procedure;
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;
- The surgical repair of damage resulting to a patient from a planned surgical procedure; and
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

There are currently no requirements for any hospital to participate in the Florida Patient Safety Corporation (FPSC) "near miss" reporting system. Near miss reporting is important to patient safety because if researchers can understand how near errors were averted they can prevent future errors.

Medical Malpractice Caps on Noneconomic Damages

In 2003, the Legislature adopted several medical malpractice reforms, including caps on noneconomic damages in an action for personal injury or wrongful death arising from medical negligence by a practitioner or nonpractitioner:

- For an injury other than a permanent vegetative state or death, noneconomic damages are capped at $500,000 from each practitioner defendant and $750,000 from a nonpractitioner defendant. However, no more than $1 million and $1.5 million can be recovered from all practitioner defendants and all nonpractitioner defendants, respectively, regardless of the number of claimants. Alternatively, the $500,000 cap and $750,000 cap can be "pierced" to allow an injured patient to recover up to $1 million and $1.5 million aggregated from all practitioner defendants and all nonpractitioner defendants, respectively, if the injury qualifies as a catastrophic injury and manifest injustice would occur if the cap was not pierced.
- For an injury that is a permanent vegetative state or death, noneconomic damages are capped at $1 million and $1.5 million from practitioner defendants and nonpractitioner defendants, respectively, regardless of the number of claimants.
- For any type of injury resulting when a practitioner provides emergency services in a hospital or life support services including transportation, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $150,000 per claimant but cannot exceed $300,000, regardless of the number of claimants or practitioner defendants. This cap only applies to injuries prior to the patient being stabilized.

- For any type of injury resulting when a nonpractitioner provides emergency services in a hospital or prehospital emergency treatment pursuant to statutory obligations, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $750,000 per claimant from all nonpractitioner defendants but cannot exceed $1.5 million, regardless of the number of claimants or nonpractitioner defendants.

Periodic Payment of Economic Damages

Periodic payments for the purposes of medical malpractice claims are allowed in section 766.202, F.S. The section authorizes the payment of an award of future economic damages through structured payments over a period of time.

"Periodic payment" is defined to mean provision for the spreading of future economic damage payments, in whole or in part, over a period of time, as follows:

- A specific finding of the dollar amount of periodic payment which will compensate for future damages after offset by collateral sources must be made;
- The defendant must post a bond or security to assure full payment of these damages awarded. The bond must be written by a company that is rated A+ by A. M. Best Company. If the defendant is unable to adequately assure full payment of the damages, all damages reduced to present value shall be paid to the claimant; and
- The provision for payment of future damages must specify the recipient or recipients of payments.

The Governor's Self Task Force on Healthcare Professional Liability Insurance recommended that the Legislature should amend the Florida Statutes to allow the periodic payment of future noneconomic damages and the Legislature should amend the Florida Statutes to terminate the payment of future economic and noneconomic damages upon the death of the plaintiff.

The courts have upheld the use of annuities to cover future payments in medical malpractice judgments in *St. Mary's Hospitals, Inc. v. Phillipe*[1] and *Tallahassee Memorial Regional Medical Center, Inc. v Kinsey*[2].

Hospitals Insuring Medical Staff

Section 766.110, F.S., currently authorizes hospitals to extend insurance coverage to their medical staff. Hospitals must charge their staff a fair market rate for the insurance provided. The bill clarifies that if a hospital self-insures, it may extend its self-insurance to its medical staff.

BACKGROUND

The Florida Patient Safety Corporation

The Florida Patient Safety Corporation (FPSC) was created as part of the medical malpractice legislation passed after many special sessions in 2002 and was established by the Legislature in 2004. HB 1629 created the Corporation, under s. 381.0271, F.S.

The FPSC does not regulate health care providers in the state. The FPSC is intended to serve as a learning organization, assist health care providers to improve the quality and safety of health care, reduce harm to patients, and work with a consortium of patient safety centers and other patient safety programs within the state.

[1] 699 So.2d 1017 (Fla. 1st DCA 1997), reh'g denied (Oct. 22, 1997)
[2] 655 So.2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995), review denied, 622 So. 2d 344

Only a handful of states have taken the initiative to establish patient safety organizations. Florida has the most comprehensive patient safety mandate. The Legislature mandated a long list of important tasks for the FPSC. House Health Care Regulation Committee staff has monitored the development of the FPSC by attending Board meetings, participating in conference calls, and attending select advisory meetings.

As demonstrated in their yearly Progress Report published December 1, 2005, the FPSC is moving ahead on nearly all of its mandates. One of the key duties the FPSC is charged with is creating a medical error, near miss reporting system. Near miss reporting is essential to patient safety because if researchers can understand how near errors were averted they can prevent future errors. Part of medical error prevention involves looking into medical errors and "near misses" to find the root cause of the errors. The near miss data reporting system is being developed in coordination with the University of Miami/JMH Center for Patient Safety, Marsh/STARS, and CRG Medical. The near miss reporting system will have the following characteristics:

- Reporting will be voluntary, anonymous and independent of mandatory reporting systems used for regulatory purposes;
- Reports of near miss data will be published regularly;
- Special alerts will be published regarding newly identified significant risks;
- Aggregated data will be made publicly available; and
- The FPSC will report the performance and result of the near miss project in its annual report.

The FPSC expects to go live with the near miss reporting system in March 2006 and is currently recruiting hospitals to participate.

Spotlight Patient Safety: The Institute of Medicine, *To Err is Human* Report

Since the National Institute of Medicine (IOM) released *To Err is Human: Building a Safety Health System*[3] in 1999, the nation has been trying to make the institution of medicine safer. The IOM report concluded that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Medical errors result in more deaths than breast cancer, AIDS, or car accidents. Further, the report concluded that 1 in 25 hospital patients are injured by medical errors. These errors come at a large cost to society. IOM estimates that medical errors cost approximately $37.6 billion each year and that about $17 to $29 billion of the costs are associated with preventable errors.[4]

The IOM report in 1999 brought patient safety into the political spotlight. The federal government, provider organizations, purchasers, and consumers are all focused on the issue. The states, with their responsibility to protect public health and safety, addressed patient safety in a number of ways. The National Academy for State Health Policy (NASHP) reports that initially States concentrated on the idea of mandatory adverse incident reporting. More recently, states have been moving towards a systems approach to patient safety. States recognize that in order to improve the safety of the health care system, they must collaborate with providers, consumers, and purchasers; provide leadership to establish clear goals; develop useful benchmarks to measure progress; and coordinate across all agencies of state government to achieve desired outcomes.[5]

A Systems Problem: Most Medical Errors Preventable

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivery of care and not to blame individuals. Health care professionals are human and, consequently, they

[3]Institute of Medicine, To Err is Human: Building a Safer Health System, Institute of Medicine, (Washington, D.C.: National Academy Press 1999).
[4] Berntsen, K.J., "How Far Has Healthcare Come since, To Err is Human?" Journal of Nurse Care Quality 19 (2004): 5-7.
[5] Rosenthal, J. & Booth, M., "The Flood Tide Forum – State Patient Safety Centers: A new approach to promote patient safety," National Institute on State Health Policy (2004).

make mistakes. But research has shown that system improvements can substantially reduce the error rates and improve the quality of health care.

The Case for Patient Safety Incentives

There is widespread agreement that the health care system is broken. Costs are rising and there are deficiencies in quality of care and reliability of care. Incentives are one of the techniques recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) to create systems change. Financial incentives are one of the most powerful tools for bringing about behavioral change.[6] Re-aligning the financial incentives at the heart of our current health care system to focus on quality of care, safety, and outcomes is long over due.

Currently, provider reimbursement depends less on the quality of care and resulting health outcomes, and more on the intensity and frequency of services delivered. Florida Statutes provide for incentives as, "a mechanism for recognizing the achievement of performance standards or for motivating performance that exceeds performance standards (s. 216.011, F.S.).

Ideally, realignment of incentives can benefit all stakeholders. Payers, including employers and health plans, can benefit from reduced direct costs due to improved care and outcomes. Employers also can benefit from indirect cost reductions due to increased on-the-job productivity and reduced absenteeism through workers receiving better care. Physicians and hospitals can gain financial rewards and the benefits of increased visibility and recognition for performance excellence and potentially reduce malpractice claims. Finally, consumers can gain from greater choice and access to higher quality of care.[7]

The most popular incentive programs offer financial rewards to increase quality, manage costs, increase patient satisfaction, or invest in and implement technology. Although most incentives are monetary, programs may utilize a combination of financial and non-financial rewards.

Florida Statutory Teaching Hospitals

The incentives created by the bill are only eligible to statutory teaching hospitals. There are currently six major teaching hospitals. They include:

- University Medical Center (UMC) in Jacksonville, affiliated with the University of Florida;
- Mount Sinai Hospital (MSH) in Dade County, affiliated with the University of Miami;
- Jackson Memorial (JM)[8] in Dade County, affiliated with the University of Miami;
- Shands Teaching Hospital in Gainesville, affiliated with University of Florida;
- Tampa General (TG), affiliated with University of South Florida; and
- Orlando Regional Medical Center (ORMC), affiliated with the University of Florida.

One of the primary missions of the six Florida teaching hospitals is to train interning physicians and a second is to provide primary sites of care for Florida's indigent population. Each teaching facility receives public subsidies (taxes, grants, and other public revenue) to assist with financing these missions. The range of indigent care and therefore public subsidy support (and operational losses) varies widely.

The six major teaching hospitals account for 80 percent of all graduate medical education (i.e., medical residents), 50 percent of all indigent care, and 30 percent of all Medicaid treatment in Florida. Everyday, Florida's statutory teaching hospitals deliver high quality tertiary health care services to thousands of needy

[6] "Principles for the Construct of Pay-For-Performance Programs," Joint Commission on Accreditation of Healthcare Organizations (2005) Online at: [www.jcaho.org].
[7] Conklin, J., & Weiss, A., "Pay-for-performance: Assembling the building blocks of a sustainable program," Thomson Medstat, Online at: [www.medstat.com].
[8] Jackson Memorial currently has sovereign immunity.

patients. These patients often present themselves with advanced disease and are therefore at higher risk for poor health outcomes.[9]

Kluger Test for Limitations on Access to Courts

Kluger v. White, 281 So.2d 1 (Fla. 1973) established the general proposition that the Legislature may abridge a common law right to recover damages in a civil action (without offending Florida's constitutional right of access to courts) upon a showing of "commensurate benefit" to potential claimants or "an overwhelming public necessity" and proof of "no alternative" for the legislative enactment.

The first prong of the *Kluger* test has been used to sustain the constitutionality of statutory limitations on damages for personal injury in certain automobile accidents, industrial accidents, and birth related neurological injuries.

The second prong of *Kluger* has been used to uphold the constitutionality of legislation providing for a contingent cap on noneconomic damages tied to an early resolution scheme in medical malpractice cases.[10]

Recent Nationwide limits on Medical Malpractice

Medical malpractice tort law has always been maintained at the state level. All states have at least some laws governing medical liability lawsuits. The vast majority of states have statutes of limitation of two years for standard medical malpractice claims. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees.

In 2005 alone, 48 state legislatures responded to calls for medical liability reform through the introduction of some 400 bills to address the situation. Solutions ranged from enacting limits on noneconomic damages, to malpractice insurance reform, to gathering lawsuit claim data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. During the 2005 legislative session, 32 states enacted over 60 bills, and 2 more states had Supreme Court rulings relating to medical liability lawsuit statutes. Some states chose to enact a number of reforms within one bill; other states enacted a number of bills, each addressing one or two points of medical liability reform. The solutions proposed and variety of aspects addressed in the state legislation demonstrate the diversity of the problem of medical liability insurance costs from state to state. 2003 and 2004 also saw discussion and debate in the state legislatures as they progressed through concerns on medical liability costs.[11]

C. SECTION DIRECTORY:

Section 1. – Creates the short title, "Patient Safety and Provider Liability Act."

Section 2. – Provides legislative findings relating to medical malpractice insurance, role of hospitals, statutory teaching hospitals, and patient safety.

Section 3. – Amends s. 766.110, F.S., to allow hospitals to extend insurance or self-insurance to their medical staff.

Section 4. – Amends s. 766.118, F.S., to provide a $500,000 cap on medical malpractice noneconomic damages for qualifying statutory teaching hospitals.

Section 5. – Creates s. 766.401, F.S., to provide definitions.

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[9] Information supplied by the University of Miami, 2005.
[10] *University of Miami v. Echarte,* 618 So.2d 189
[11] National Conference of State Legislatures, Medical Malpractice Tort Reform, 2006.

Section 6. – Creates s. 766.402, F.S., to provide for the Agency for Health Care Administration to approve statutory teaching hospital patient-safety plans.

Section 7. – Creates s. 766.403, F.S., to provide standards for patient-safety plans.

Section 8. – Creates s. 766.404, F.S., to direct each certificated patient-safety facility to submit an annual report to the Agency for Health Care Administration.

Section 9. – Creates s. 766.405, F.S., to allow for economic damages awarded in a medical malpractice case to be paid through periodic payments in the form of an annuity or a reversionary trust.

Section 10. – Creates s. 766.406, F.S., to give AHCA rulemaking authority to administer ss. 766.401-766.405, F.S.

Section 11. – Provides that the provisions of this act are severable.

Section 12. – Provides that this act shall govern in the instance of conflicts with professional licensing statutes.

Section 13. – States that the Legislature intends that the provisions of this act are self-executing.

Section 14. – Provides that this act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

It is unclear how many eligible hospitals would submit a patient safety plan to be certified by the Agency for Health Care Administration (AHCA). AHCA may incur a cost to certify patient safety plans created in the bill. AHCA did not provide the Health Care Regulation Committee with an estimated fiscal impact.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

Article I, section 21, of the Florida Constitution, guarantees access to courts, providing as follows:

> The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.

The Florida Supreme Court has consistently[12] held that the Legislature may not impose a monetary cap on noneconomic damages unless it provides a commensurate benefit, or it shows:

- An overpowering public necessity for the abolishment of the right to such damages exists; and
- There is no alternative method of meeting the public necessity.

B. RULE-MAKING AUTHORITY:

The bill provides the necessary rule making authority to carry out the provisions in the act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 22, 2006 the Health Care Regulation Committee adopted 5 amendments and reported the bill favorably.

- **Amendment 1:** Removes section three of the bill because insurance companies may already offer medical malpractice policies that exclude hospital coverage under current law.
- **Amendment 2:** Technical amendment that specifies that a hospital does not need a verified trauma center on the premises to extend insurance or self-insurance to its medical staff.
- **Amendment 3:** Clarifies that insurance coverage offered by hospitals to their medical staff must be limited to the hospital premises.
- **Amendment 4:** Allows "approved" insurers the option to offer insurance packages that allow hospital to insure their medical staff.
- **Amendment 5:** Clarifies that the benefits of caps on noneconomic damages and periodic payments apply only when eligible hospitals are employing physicians "full-time."

The analysis is drafted to the committee substitute.

[12] *Smith v. Department of Insurance*, 507 So. D2 1080 (Fla. 1987), *Kuger v. White*, 281 So.2d 1 (Fla. 1973)

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to medical malpractice insurance; providing a short title; creating the Patient Safety and Provider Liability Act; providing legislative findings; amending s. 766.110, F.S.; specifying certain authorized insurers who may make available liability insurance; amending s. 766.118, F.S.; providing a limitation on noneconomic damages for a hospital facility that complies with certain patient-safety measures; creating s. 766.401, F.S.; providing definitions; creating s. 766.402, F.S.; authorizing an eligible hospital to petition the agency for an order certifying the hospital as a certified patient-safety facility; providing requirements for certification as a patient-safety facility; authorizing the agency to conduct onsite examinations; providing for revocation of an order certifying approval of a certified patient-safety facility; providing that an order certifying the approval of a certified patient-safety facility is conclusive evidence of compliance with

statutory patient-safety requirements; providing that evidence of noncompliance is not admissible for any action for medical malpractice; creating s. 766.403, F.S.; providing requirements for a hospital to demonstrate that it is engaged in a common enterprise for the care and treatment of patients; specifying required patient-safety measures; prohibiting a report or document generated under the act from being admissible or discoverable as evidence; creating s. 766.404, F.S.; requiring a certified patient-safety facility to submit an annual report to the agency and the Legislature; providing requirements for the annual report; providing that the annual report may include certain information from the Office of Insurance Regulation within the Department of Financial Services; providing that the annual report is subject to public-records requirements but is not admissible as evidence in a legal proceeding; creating s. 766.405, F.S.; providing for limitations on damages for eligible hospitals that are certified for compliance with certain patient-safety measures; creating s. 766.406, F.S.; providing rulemaking authority; providing for severability; providing for broad statutory view of the act; providing for self-execution of the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Short title.--This act may be cited as the "Patient Safety and Provider Liability Act."

Section 2. Legislative findings.--The Legislature finds that:

(1) This state is in the midst of a prolonged medical malpractice insurance crisis that has serious adverse effects on patients, practitioners, licensed health care facilities, and all residents of this state.

(2) Hospitals are central components of the modern health care delivery system.

(3) The medical malpractice insurance crisis in this state can be alleviated by the adoption of innovative approaches for patient safety in teaching hospitals, which can lead to a reduction in medical errors coupled with a limitation on noneconomic damages that can be awarded against a teaching hospital that implements such innovative approaches.

(4) Statutory incentives are necessary to facilitate innovative approaches for patient safety in hospitals and that such incentives and patient-safety measures will benefit all persons seeking health care services in this state.

(5) Coupling patient safety measures and a limitation on provider liability in teaching hospitals will lead to a reduction in the frequency and severity of incidents of medical malpractice in hospitals.

(6) A reduction in the frequency and severity of incidents of medical malpractice in hospitals will reduce attorney's fees and other expenses inherent in the medical liability system.

(7) There is no alternative method that addresses the overwhelming public necessity to implement patient-safety measures and limit provider liability.

(8) Making high-quality health care available to the residents of this state is an overwhelming public necessity.

(9) Medical education in this state is an overwhelming public necessity.

(10) Statutory teaching hospitals are essential for high-quality medical care and medical education in this state.

(11) The critical mission of statutory teaching hospitals is severely undermined by the ongoing medical malpractice crisis.

(12) Teaching hospitals are appropriate health care facilities for the implementation of innovative approaches to enhancing patient safety and limiting provider liability.

(13) There is an overwhelming public necessity to impose reasonable limitations on actions for medical malpractice against teaching hospitals in furtherance of the critical public interest in promoting access to high-quality medical care, medical education, and innovative approaches to patient safety and provider liability.

(14) There is an overwhelming public necessity for teaching hospitals to implement innovative measures for patient safety and limit provider liability in order to generate empirical data for state policymakers concerning the effectiveness of these measures. Such data may lead to broader application of these measures in a wider array of hospitals after a reasonable period of evaluation and review.

(15) There is an overwhelming public necessity to promote the academic mission of teaching hospitals. Furthermore, the Legislature finds that the academic mission of these medical

facilities is materially enhanced by statutory authority for the implementation of innovative approaches to promoting patient safety and limiting provider liability. Such approaches can be carefully studied and learned by medical students, medical school faculty, and affiliated physicians in appropriate clinical settings, thereby enlarging the body of knowledge concerning patient safety and provider liability which is essential for advancement of patient safety, reduction of expenses inherent in the medical liability system, and curtailment of the medical malpractice insurance crisis in this state.

Section 3. Subsection (2) of section 766.110, Florida Statutes, is amended to read:

766.110 Liability of health care facilities.--

(2) Every hospital licensed under chapter 395 may carry liability insurance or adequately insure itself in an amount of not less than $1.5 million per claim, $5 million annual aggregate to cover all medical injuries to patients resulting from negligent acts or omissions on the part of those members of its medical staff who are covered thereby in furtherance of the requirements of ss. 458.320 and 459.0085. Notwithstanding s. 626.901, a licensed hospital may extend insurance and self-insurance coverage to members of the medical staff, including physicians' practices, individually or through a professional association, as defined in chapter 621, and other health care practitioners, as defined in s. 456.001(4), including students preparing for licensure. Such coverage shall be limited to legal liability arising out of medical negligence within the hospital

premises as defined under s. 766.401. ~~Self-insurance~~ Coverage extended hereunder to a member of a hospital's medical staff meets the financial responsibility requirements of ss. 458.320 and 459.0085 if the physician's coverage limits are not less than the minimum limits established in ss. 458.320 and 459.0085 ~~and the hospital is a verified trauma center that has extended self-insurance coverage continuously to members of its medical staff for activities both inside and outside of the hospital~~. Any approved insurer, authorized insurer as defined in s. 624.09, risk retention group as defined in s. 627.942, or joint underwriting association established under s. 627.351(4) which is approved or authorized to write casualty insurance may make available, but is ~~shall~~ not ~~be~~ required to write, such coverage. The hospital may assess on an equitable and pro rata basis the following individuals to whom it extends coverage pursuant to this section ~~professional health care providers~~ for a portion of the total hospital insurance cost for this coverage: physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatric physicians licensed under chapter 461, dentists licensed under chapter 466, ~~and~~ nurses licensed under part I of chapter 464, and other health professionals. The hospital may provide for a deductible amount to be applied against any individual health care provider found liable in a law suit in tort or for breach of contract. The legislative intent in providing for the deductible to be applied to individual health care providers found negligent or in breach of contract is to instill in each individual health care provider the incentive to avoid the risk of injury to the fullest extent

and ensure that the citizens of this state receive the highest quality health care obtainable.

Section 4. Present subsections (6) and (7) of section 766.118, Florida Statutes, are renumbered as subsections (7) and (8), respectively, and a new subsection (6) is added to that section, to read:

766.118 Determination of noneconomic damages.--

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF CERTAIN HOSPITALS.--With respect to a complaint for personal injury or wrongful death arising from medical negligence, a hospital that has received an order from the Agency for Health Care Administration pursuant to s. 766.402 which certifies that the facility complies with patient-safety measures specified in s. 766.403 shall be liable for no more than $500,000 in noneconomic damages, regardless of the number of claimants, number of claims, or theory of liability, including vicarious liability, arising from the same nucleus of operative fact, notwithstanding any other provision of this section.

Section 5. Section 766.401, Florida Statutes, is created to read:

766.401 Definitions.--As used in this section and ss. 766.402-766.405, the term:

(1) "Affected patient" means a patient of a certified patient-safety facility.

(2) "Affected practitioner" means any person, including a physician, who is credentialed by the eligible hospital to provide health care services in a certified patient-safety facility.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Certified patient-safety facility" means any eligible hospital that, in accordance with an order from the Agency for Health Care Administration, has adopted a patient-safety plan.

(5) "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to render patient-care services in a hospital.

(6) "Eligible hospital" or "licensed facility" means a statutory teaching hospital, as defined by s. 408.07, which maintains at least seven different accredited programs in graduate medical education and has 100 or more full-time equivalent resident physicians.

(7) "Health care provider" or "provider" means:

(a) An eligible hospital.

(b) A physician or a physician assistant licensed under chapter 458.

(c) An osteopathic physician or an osteopathic physician assistant licensed under chapter 459.

(d) A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility that employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered by that facility.

(e) A health care professional association and its employees or a corporate medical group and its employees.

(f) Any other medical facility in which the primary purpose is to deliver human medical diagnostic services or to deliver nonsurgical human medical treatment, including an office maintained by a provider.

(g) A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to low-income persons not otherwise covered by Medicaid or other programs for low-income persons.

(h) Any other health care professional, practitioner, or provider, including a student enrolled in an accredited program, who prepares the student for licensure as any one of the professionals listed in this subsection.

(i) Any person, organization, or entity that is vicariously liable under the theory of respondeat superior or any other theory of legal liability for medical negligence committed by any licensed professional listed in this subsection.

(j) Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c) of the Internal Revenue Code, including any university or medical school that employs licensed professionals listed in this subsection or which delivers health care services provided by licensed professionals listed in this subsection, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(8) "Health care practitioner" or "practitioner" means any person, entity, or organization identified in subsection (7), except for a hospital.

(9) "Medical incident" or "adverse incident" has the same meaning as provided in ss. 381.0271, 395.0197, 458.351, and 459.026.

(10) "Medical negligence" means medical malpractice, whether grounded in tort or in contract, arising out of the rendering of or failure to render medical care or services.

(11) "Person" means any individual, partnership, corporation, association, or governmental unit.

(12) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of the hospital, ambulatory surgical, mobile surgical care, primary care, or comprehensive health care under the dominion and control of the licensee, including offices and locations where the licensed facility offers medical care and treatment to affected patients.

(13) "Statutory teaching hospital" or "teaching hospital" has the same meaning as provided in s. 408.07.

Section 6. Section 766.402, Florida Statutes, is created to read:

766.402 Agency approval of patient-safety plans.--

(1) An eligible hospital that has adopted a patient-safety plan may petition the agency to enter an order certifying approval of the hospital as a certified patient-safety facility.

(2) In accordance with chapter 120, the agency shall enter an order certifying approval of the certified patient-safety facility upon a showing that, in furtherance of an approach to patient safety:

(a) The petitioner has established safety measures for the care and treatment of patients.

(b) The petitioner satisfies requirements for patient-protection measures, as specified in s. 766.403.

(c) The petitioner satisfies all other requirements of ss. 766.401-766.405.

(3) Upon entry of an order approving the petition, the agency may conduct onsite examinations of the licensed facility to ensure continued compliance with the terms and conditions of the order.

(4) The order approving a petition under this section remains in effect until revoked. The agency may revoke the order upon reasonable notice to the eligible hospital that it fails to comply with material requirements of s. 766.403 and that the hospital has failed to cure stated deficiencies upon reasonable notice. Revocation of an agency order pursuant to s. 766.403 applies prospectively to any cause of action for medical negligence which arises on or after the effective date of the order of revocation.

(5) An order approving a petition under this section is, as a matter of law, conclusive evidence that the hospital complies with the applicable patient-safety requirements of s. 766.403. A hospital's noncompliance with the requirements of s. 766.403 does not affect the limitations on damages conferred by

this section. Evidence of noncompliance with s. 766.403 is not admissible for any purpose in any action for medical malpractice. This section, or any portion thereof, may not give rise to an independent cause of action for damages against any hospital.

Section 7. Section 766.403, Florida Statutes, is created to read:

766.403 Patient-safety plans.--

(1) In order to satisfy the requirements of s. 766.402, the licensed facility shall have a patient-safety plan, which provides that the facility shall:

(a) Have in place a process, either through the facility's patient-safety committee or a similar body, for coordinating the quality control, risk management, and patient-relations functions of the facility and for reporting to the facility's governing board at least quarterly regarding such efforts.

(b) Establish within the facility a system for reporting near misses and agree to submit any information collected to the Florida Patient Safety Corporation. Such information must be submitted by the facility and made available by the Patient Safety Corporation in accordance with s. 381.0271(7).

(c) Design and make available to facility staff, including medical staff, a patient-safety curriculum that provides lecture and web-based training on recognized patient-safety principles, which may include training in communication skills, team-performance assessment and training, risk-prevention strategies, and best practices and evidence-based medicine. The licensed

facility shall report annually the programs presented to the agency.

(d) Implement a program to identify health care providers on the facility's staff who may be eligible for an early-intervention program that provides additional skills assessment and training and offer such training to the staff on a voluntary and confidential basis with established mechanisms to assess program performance and results.

(e) Implement a simulation-based program for skills assessment, training, and retraining of a facility's staff in those tasks and activities that the agency identifies by rule.

(f) Designate a patient advocate who coordinates with members of the medical staff and the facility's chief medical officer regarding the disclosure of adverse medical incidents to patients. In addition, the patient advocate shall establish an advisory panel, consisting of providers, patients or their families, and other health care consumers or consumer groups to review general patient-safety concerns and other issues related to relations among and between patients and providers and to identify areas where additional education and program development may be appropriate.

(g) Establish a procedure to biennially review the facility's patient-safety program and its compliance with the requirements of this section. Such review shall be conducted by an independent patient-safety organization as defined in s. 766.1016(1) or other professional organization approved by the agency. The organization performing the review shall prepare a written report that contains detailed findings and

recommendations. The report shall be forwarded to the facility's risk manager or patient-safety officer, who may make written comments in response. The report and any written comments shall be presented to the governing board of the licensed facility. A copy of the report and any of the facility's responses to the findings and recommendations shall be provided to the agency within 60 days after the date that the governing board reviewed the report. The report is confidential and exempt from production or discovery in any civil action. Likewise, the report and the information contained therein are not admissible as evidence for any purpose in any action for medical negligence.

(h) Establish a system for the trending and tracking of quality and patient-safety indicators that the agency may identify by rule and a method for review of the data at least semiannually by the facility's patient-safety committee.

(2) This section does not constitute an applicable standard of care in any action for medical negligence or otherwise create a private right of action, and evidence of noncompliance with this section is not admissible for any purpose in any action for medical negligence against any health care provider.

(3) This section does not prohibit the licensed facility from implementing other measures for promoting patient safety within the premises. This section does not relieve the licensed facility from the duty to implement any other patient-safety measure that is required by state law. The Legislature intends that the patient-safety measures specified in this section are

in addition to all other patient-safety measures required by state law, federal law, and applicable accreditation standards for licensed facilities.

(4) A review, report, or other document created, produced, delivered, or discussed pursuant to this section is not discoverable or admissible as evidence in any legal action.

Section 8. Section 766.404, Florida Statutes, is created to read:

766.404 Annual report.--

(1) Each certified patient-safety facility shall submit an annual report to the agency containing information and data reasonably required by the agency to evaluate performance and effectiveness of its patient-safety plan. However, information may not be submitted or disclosed in violation of any patient's right to privacy under state or federal law.

(2) The agency shall aggregate information and data submitted by all certified patient-safety facilities, and each year, on or before March 1, the agency shall submit a report to the President of the Senate and the Speaker of the House of Representatives which evaluates the performance and effectiveness of the approach to enhancing patient safety and limiting provider liability in certified patient-safety facilities. The report must include, but need not be limited to, pertinent data concerning:

(a) The number and names of certified patient-safety facilities;

(b) The number and types of patient-protection measures currently in effect in these facilities;

(c) The number of affected patients;

(d) The number of surgical procedures on affected patients;

(e) The number of medical incidents, claims of medical malpractice, and claims resulting in indemnity;

(f) The average time for resolution of contested and uncontested claims of medical malpractice;

(g) The percentage of claims which result in civil trials;

(h) The percentage of civil trials which result in adverse judgments against affected facilities;

(i) The number and average size of an indemnity paid to claimants;

(j) The estimated liability expense, inclusive of medical liability insurance premiums; and

(k) The percentage of medical liability expense, inclusive of medical liability insurance premiums, which is borne by affected practitioners in certified patient-safety facilities.

The report may also include other information and data that the agency deems appropriate to gauge the cost and benefit of patient-safety plans.

(3) The agency's annual report to the President of the Senate and the Speaker of the House of Representatives may include relevant information and data obtained from the Office of Insurance Regulation within the Department of Financial Services concerning the availability and affordability of enterprise-wide medical liability insurance coverage for affected facilities and the availability and affordability of

insurance policies for individual practitioners which contain coverage exclusions for acts of medical negligence in facilities that indemnify health practitioners. The Office of Insurance Regulation shall cooperate with the agency in the reporting of information and data specified in this subsection.

(4) Reports submitted to the agency by certified patient-safety facilities pursuant to this section are public records under chapter 119. However, these reports, and the information contained therein, are not admissible as evidence in a court of law in any action.

Section 9. Section 766.405, Florida Statutes, is created to read:

766.405 Damages in malpractice actions against certain hospitals that meet patient-safety requirements; agency approval of patient-safety measures.--

(1) In recognition of their essential role in training future health care providers and in providing innovative medical care for this state's residents, in recognition of their commitment to treating indigent patients, and further in recognition that teaching hospitals, as defined in s. 408.07, provide benefits to the residents of this state through their roles in improving the quality of medical care, training of health care providers, and caring for indigent patients, the limits of liability for medical malpractice arising out of the rendering of, or the failure to render, medical care by all such hospitals shall be determined in accordance with the requirements of this section.

(2) Upon entry of an order and for the entire period of time that the order remains in effect, the damages recoverable from an eligible hospital covered by the order and from its full-time physician employees, full-time and part-time nonphysician employees, and agents in actions arising from medical negligence shall be determined in accordance with the following provisions:

(a) Noneconomic damages shall be limited to a maximum of $500,000, regardless of the number of claimants, number of claims, or the theory of liability pursuant to s. 766.118(6).

(b) Awards of economic damages shall be offset by payments from collateral sources, as defined by s. 766.202(2), and any set-offs available under ss. 46.015 and 768.041. Awards for future economic losses shall be offset by future collateral source payments.

(c) After being offset by collateral sources, awards of future economic damages shall, at the option of the eligible hospital, be reduced by the court to present value or paid through periodic payments in the form of an annuity or a reversionary trust. A company that underwrites an annuity to pay future economic damages shall have a rating of "A" or higher by A.M. Best Company. The terms of the reversionary instrument used to periodically pay future economic damages must be approved by the court. Such approval may not be unreasonably withheld.

(3) The limitations on damages in subsection (2) apply prospectively to causes of action for medical negligence which arise on or after the effective date of the order.

Section 10. Section 766.406, Florida Statutes, is created to read:

766.406 Rulemaking authority.--The agency may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer ss. 766.401-766.405.

Section 11. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are severable.

Section 12. If a conflict exists between any provision of this act and s. 456.052, s. 456.053, s. 456.054, s. 458.331, s. 459.015, or s. 817.505, Florida Statutes, the provisions of this act shall govern. The provisions of this act shall be broadly construed in furtherance of the overriding legislative intent to facilitate innovative approaches for enhancing patient protection and limiting provider liability in eligible hospitals.

Section 13. It is the intention of the Legislature that the provisions of this act are self-executing.

Section 14. This act shall take effect upon becoming a law.

HB 1293 CS Amendment by Rep. Grant

The amendment is technical. It clarifies that insurance companies may offer insurance for hospitals that wish to insure their medical staff.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No.____(for drafter's use only)

Bill No. **HB 1293 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Grant offered the following:

Amendment (with directory and title amendments)

Remove line(s) 144-145 and insert:

Any authorized insurer, approved insurer as defined in s. 626.914(2), risk retention group as defined in s. 627.942, or joint

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1411 Public Records
SPONSOR(S): Benson
TIED BILLS: HB 1409 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N	Bell	Mitchell
2) Governmental Operations Committee	6 Y, 0 N	Williamson	Williamson
3) Health & Families Council		Bell AJB	Moore MPM
4)			
5)			

SUMMARY ANALYSIS

HB 1411 creates a public records exemption for certain information held by the Florida Health Information Network, Inc., established in HB 1409. Information made confidential and exempt includes:

- A patient's medical or health record;
- Trade secrets as defined in the Uniform Trade Secrets Act; and
- Any information received from a person from another state or nation or the Federal Government, which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

HB 1411 is linked to HB 1409. HB 1409 creates the "Florida Health Information Network Act" as a nexus towards a public/private partnership that will implement a statewide electronic medical records network.

The bill provides for future review and repeal of the exemption on October 2, 2011, provides a statement of public necessity, and provides a contingent effective date.

The bill requires a two-thirds vote of the members present and voting for passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill limits access to public records.

Safeguard Individual Liberty – The bill provides that patient medical records or health records held by the Florida Health Information Network, Inc., are confidential and exempt from public disclosure.

B. EFFECT OF PROPOSED CHANGES:

HB 1411 creates s. 408.0641, F.S., to provide a public records exemption for certain information held by the Florida Health Information Network, Inc. The confidential and exempt[1] information includes:

- A patient's medical or health record;
- Trade secrets as defined in the Uniform Trade Secrets Act;[2] and
- Any information received from a person from another state or nation or the Federal Government, which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

The bill provides for future review and repeal of the exemption on October 2, 2011, pursuant to the Open Government Sunset Review Act.[3] It also provides a statement of public necessity and provides a contingent effective date.

HB 1409

HB 1409 creates the Florida Health Information Network Act as a public/private partnership that will implement a statewide electronic medical records network. It establishes the Florida Health Information Network, Inc., as a not-for-profit corporation, which will be managed by an uncompensated board of directors. The initial board will consist of the current Governor's Health Information Infrastructure Advisory Board (for 18 months).

The primary duties of the Florida Health Information Network, Inc., are to oversee, coordinate, and implement a statewide electronic medical records network. Among the many duties listed in the enabling legislation, the Florida Health Information Network is charged with development of technical standards for electronic medical records and recruiting participants into the network.

The Agency for Health Care Administration (AHCA) will provide oversight of the Florida Health Information Network, Inc.

C. SECTION DIRECTORY:

Section 1. - Creates s. 408.0641, F.S., to create a public records exemption for the Florida Health Information Network, Inc.

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[1] There is a difference between records that are exempt from public records requirements and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such record cannot be released by an agency to anyone other than to the persons or entities designated in the statute. *See* Attorney General Opinion 85-62. If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances. *See Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d 289 (Fla. 1991).

[2] Section 688.002, F.S.

[3] Section 119.15, F.S.

Section 2. - Provides a statement of public necessity.

Section 3. - Provides a contingent effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

   This bill does not create, modify, amend, or eliminate a state expenditure.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   This bill does not create, modify, amend, or eliminate a local revenue source.

2. Expenditures:

   This bill does not create, modify, amend, or eliminate a local expenditure.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill likely could create a fiscal impact on the Florida Health Information Network, Inc., because staff responsible for complying with public records requests will require training relating to the newly created public records exemption. In addition, the Florida Health Information Network, Inc., could incur costs associated with redacting the confidential and exempt information prior to releasing a record.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   Vote Requirement

   Article I, s. 24(c) of the Florida Constitution, requires a two-thirds vote of the members present and voting for passage of a newly created public records or public meetings exemption. The bill creates a public records exemption. Thus, it requires a two-thirds vote for passage.

Public Necessity Statement

Article I, s. 24(c) of the Florida Constitution, requires a statement of public necessity (public necessity statement) for a newly created public records or public meetings exemption. The bill creates a public records exemption. Thus, it includes a public necessity statement.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Public Records Law

Article I, s. 24(a), Florida Constitution, sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. Article I, s. 24(b), Florida Constitution, sets forth the state's public policy regarding access to government meetings. The section requires all meetings of the executive branch and local government be open and noticed to the public.

The Legislature may, however, provide by general law for the exemption of records and meetings from the requirements of Article I, s. 24, Florida Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose.

Public policy regarding access to government records and meetings is also addressed in the Florida Statutes. Section 119.07(1), F.S., also guarantees every person a right to inspect, examine, and copy any state, county, or municipal record, and s. 286.011, F.S., requires that all state, county, or municipal meetings be open and noticed to the public. Furthermore, the Open Government Sunset Review Act of 1995[4] provides that a public records or public meetings exemption may be created or maintained only if it serves an identifiable public purpose, and may be no broader than is necessary to meet one of the following public purposes:

- Allowing the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protecting sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety. However, only the identity of an individual may be exempted under this provision; or,
- Protecting trade or business secrets.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[4] Section 119.15, F.S.

A bill to be entitled

An act relating to public records; creating s. 408.0641, F.S.; providing an exemption from public records requirements for patient medical or health records, trade secrets, and certain other information that is confidential or exempt contained in records of the Florida Health Information Network, Inc.; providing for review and repeal; providing a statement of public necessity; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.0641, Florida Statutes, is created to read:

408.0641 Florida Health Information Network, Inc.; public records exemption.--

(1) The following information held by the Florida Health Information Network, Inc., is confidential and exempt from of s. 119.07(1) and s. 24, Art. I of the State Constitution:

(a) A patient's medical or health record.

(b) Trade secrets as defined in s. 688.002.

(c) Any information received from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

(2) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed

on October 2, 2011, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that a patient's medical or health record held by the Florida Health Information Network, Inc., a not-for-profit corporation, be made confidential and exempt from public records requirements. Matters of personal health are traditionally private and confidential concerns between the patient and the health care provider. The private and confidential nature of personal health matters pervades both the public and private health care sectors. For these reasons, the individual's expectation of and right to privacy in all matters regarding his or her personal health necessitates this exemption. The Legislature further finds that it is a public necessity to protect a patient's medical record or health record because the release of such record could be defamatory to the patient or could cause unwarranted damage to the name or reputation of that patient. The Legislature also finds that it is a public necessity to protect the release of a trade secret as defined in s. 688.002, Florida Statutes. A trade secret derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use. Without an exemption from public records requirements for a trade secret as defined in s. 688.002, Florida Statutes, that trade secret becomes a public record when held by the Florida Health Information Network, Inc., and must be divulged upon request. Divulgence of any trade secret under

the public records law would destroy the value of that property. Release of that information would give business competitors an unfair advantage and weaken the position of the corporation in the marketplace. Thus, the Legislature finds that it is a public necessity that a trade secret be made confidential and exempt from public records requirements. Finally, the Legislature finds that it is a public necessity to protect information received by the Florida Health Information Network, Inc., from a person from another state or nation or the Federal Government which is otherwise exempt or confidential pursuant to the laws of that state or nation or pursuant to federal law. Without this protection, another state or nation or the Federal Government might be less likely to provide information to the corporation in the furtherance of its duties and responsibilities.

Section 3. This act shall take effect July 1, 2006, if House Bill 1409 or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.

HB 1411 Amendment by Rep. Benson

The amendment corrects a technical error and allows patient medical records to be disclosed with the written consent of the patient or in a medical emergency.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No._____ (for drafter's use only)

Bill No. **HB 1411**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Benson offered the following:

Amendment (with title amendment)

Remove line(s) 18-26 and insert:

Information Network, Inc., is confidential and exempt from s. 119.07(1) and s. 24, Art. I of the State Constitution:

(a) A patient's medical or health record.

(b) Trade secrets as defined in s. 688.002.

(c) Any information received from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

(2) A patient's medical or health record shall be disclosed:

(a) With the express written consent of the individual or the individual's legally authorized representative.

(b) In a medical emergency, but only to the extent necessary to protect the health or life of the individual.

(3) This section is subject to the Open Government Sunset

Amendment No._____(for drafter's use only)

22

23 ========== T I T L E A M E N D M E N T ==========

24 Remove line(s) 7 and insert:

25 Health Information Network, Inc.; providing an exception to the

26 exemption; providing for review and

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1561 CS Expert Witnesses
SPONSOR(S): Brummer and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2686

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	7 Y, 1 N, w/CS	Brown-Barrios	Brown-Barrios
2) Health & Families Council		Brown-Barrios	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

Currently, expert witnesses are not required to hold a Florida license or hold any Board issued certificate in order to testify in medical negligence (medical malpractice) litigation.

The bill requires an expert witness who provides testimony concerning the prevailing professional standard of care in any action for damages involving a claim of negligence against a Florida-licensed medical (allopathic) physician or osteopathic physician to be:

- A Florida-licensed medical physician or osteopathic physician or
- If licensed in another state or Canada, to hold an expert witness certificate.

The bill requires the Board of Medicine or the Board of Osteopathic Medicine to issue an expert witness certificate within five business days of receiving a completed application to any physician who:

1. is licensed to practice allopathic or osteopathic medicine in any other state or in Canada,
2. has a license that is currently active and valid,
3. completes a registration form prescribed by the board,
4. pays the application fee, and
5. has not had a previous expert witness certificate revoked by the Board of Medicine or the Board of Osteopathic Medicine.

The expert witness certificate is valid for two years. The bill defines an expert witness certificate as a license for the purpose of disciplinary action under chapter 458 and 459, F.S., and thus requiring that the procedures, protections and due process provisions afforded to a licensed medical physician and a licensed osteopathic physician in a disciplinary action also apply to the holder of an expert witness certificate. The bill authorizes the Board of Medicine and the Board of Osteopathic Medicine to adopt rules.

The bill limits a physician possessing an expert witness certificate to use the certificate solely to give a verified written medical expert opinion and to provide expert testimony concerning the prevailing professional standard of care in connection with any medical malpractice litigation pending in this state against a physician licensed in Florida.

The bill makes the act of providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine by a medical physician or osteopathic physician grounds for denial of a license or disciplinary action.

The bill has an estimated fiscal impact of $377,541 in FY 06/07 and $404,875 in FY 07/08. If enacted, the bill takes effect October 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government: The bill creates additional statutory requirements and regulations for government agencies and the public.

B. EFFECT OF PROPOSED CHANGES:

Primary effects of the bill include:

- Creation of an expert witness certificate good for two years for a medical physician or osteopathic physician licensed in another state or Canada that entitles the holder to provide verified written medical expert opinion and to provide expert testimony in medical malpractice cases.
- Limiting the admission of verified written medical expert opinion and expert testimony involving a claim of negligence against a Florida medical or osteopathic physician to physicians licensed by this state or physicians possessing an expert witness certificate.
- Defining an expert witness certificate as a license for the purpose of disciplinary action under chapter 458 and 459, F.S., and thus requiring that the procedures, protections and due process provisions afforded to a licensed medical physician and a licensed osteopathic physician in a disciplinary action also apply to the holder of an expert witness certificate.
- Granting authority to the Board of Medicine or the Board of Osteopathic Medicine to issue and revoke an expert witness certificate.
- Granting authority to the Board of Medicine or the Board of Osteopathic Medicine to deny a license or discipline a medical physician or osteopathic physician for providing misleading, deceptive, or fraudulent witness testimony related to the practice of medicine.

BACKGROUND

Medical Expert

"A Medical expert" is defined as:

> [A] person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and who meets the requirements of an expert witness as set forth in s. 766.102.[1]

Expert Witness Requirements in a medical negligence proceeding

Florida law provides that in a medical negligence or medical malpractice[2] proceeding a person may not give expert testimony against or on behalf of the defendant concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets certain requirements and conditions of health care providers for the purpose of testifying in court. There are no requirements in current law that an expert witness must have a Florida license.[3]

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[1] s. 766.202(6),F.S.
[2] s. 766.202(7),F.S.
[3] s. 766.102, F.S.

If the health care provider against whom or on whose behalf the testimony is offered is a specialist [4]

The expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and
2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
    a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;
    b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or
    c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner. [5]

The expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice or consultation as a general practitioner;
2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner. [6]

The expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;
2. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or
3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.

Other requirements and conditions for providing expert testimony.

A physician licensed under chapter 458, F.S., or chapter 459, F.S., who qualifies as an expert witness and who, by reason of active clinical practice or instruction of students, has knowledge of the applicable standard of care for nurses, nurse practitioners, certified registered nurse anesthetists, certified registered nurse midwives, physician assistants, or other medical support staff may give expert testimony in a medical negligence action with respect to the standard of care of medical support staff.[7]

In a medical negligence action against a hospital, a health care facility, or medical facility, a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical

[4] s. 766.102(5)(a), F.S.
[5] s. 766.102(5)(b), F.S.
[6] s. 766.102(5)(c), F.S.
[7] s. 766.102(6), F.S.

issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, health care facilities, or medical facilities of the same type as the hospital, health care facility, or medical facility whose acts or omissions are the subject of the testimony and which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.[8]
If a health care provider is providing evaluation, treatment, or diagnosis for a condition that is not within his or her specialty, a specialist trained in the evaluation, treatment, or diagnosis for that condition is considered a similar health care provider.[9]

In any action for damages involving a claim of negligence against a physician licensed under chapter 458, F.S., osteopathic physician licensed under chapter 459, F.S., podiatric physician licensed under chapter 461, F.S., or chiropractic physician licensed under chapter 460, F.S., providing emergency medical services in a hospital emergency department, the court must admit expert medical testimony only from physicians, osteopathic physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.[10]

Power of the trial court
The requirements and conditions delineated in law regarding who may provide testimony as an expert witness in a medical negligence proceeding does not limit the power of the trial court to disqualify or qualify an expert witness on other grounds.[11] In addition, in the Florida Evidence Code it is the court that determines preliminary questions concerning the qualification of a person to be a witness, the existence of a privilege, or the admissibility of evidence.[12]

The framework for expert testimony in Florida courts
Florida allows that if scientific, technical, or other specialized knowledge will assist the trier of fact (the judge or the jury) in understanding the evidence or in determining a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify about it in the form of an opinion; however, the opinion is admissible only if it can be applied to the evidence at trial.[13]

In *Frye v. United States* [14] the court laid the framework for how courts would treat expert opinion testimony based on novel scientific procedures. *Frye* became the federal standard for judges to apply in evaluating scientific evidence. In *Frye*, a defendant in a murder trial attempted to show his innocence by using a lie detector test that measured systolic blood pressure. The court excluded the evidence, reasoning that the lie detector test was unreliable because the scientific principle upon which it was based was not "sufficiently established to have gained general acceptance in the particular field in which it belongs." The implication is that one "expert" scientist testifying to the accuracy of the lie detector would not be enough and that a large community of scientists must accept the test in order for the judge to allow the jury to hear the evidence.

In Florida, the *Frye* general standard was adopted in the context of a lie detector test in a 1952 case.[15] Since then, all novel scientific evidence in Florida has been held up to the *Frye* standard. In 1995, the Florida Supreme Court, in *Ramirez v. State*, held that Florida will continue to use the *Frye* standard.[16] Consistent with s. 90.702, F.S., and the Florida Supreme Court's decision in *Ramirez*, the admission of expert opinion testimony concerning scientific principles is governed by the following four-step process:

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[8] s. 766.102(7), F.S.
[9] s. 766.102(8), F.S.
[10] s. 766.102(9)(a), F.S.
[11] s. 766.102(12), F.S.
[12] s. 90.105(1), F.S.
[13] s. 90.702, F.S.
[14] Frye v. United States, 293 F. 1013 (D.C. Cir. 1923)
[15] Kaminski v. State, 63 So. 2d 339 (Fla. 1952)
[16] Ramirez v. State, 651 So. 2d 1164, 1167 (Fla. 1995)

First, the trial judge must determine whether such expert testimony will assist the jury in understanding the evidence or in determining a fact at issue.

Second, the trial judge must decide whether the expert's testimony is based on a scientific principle or discovery that is "sufficiently established to have gained general acceptance in the particular field in which it belongs". (*Frye* standard)

Third, the trial judge must determine whether a particular witness is qualified as an expert to present opinion testimony on the subject at issue.

Fourth, the trial judge may then allow the expert to render an opinion on the subject of his or her expertise, and then it is up to the jury to determine the credibility of the expert's opinion, which it may either accept or reject.

These four steps are the basic framework that applies to Florida's statutory and case law.

The Practice of Medicine

Chapter 458, F.S., governs the practice of medicine (allopathic) in Florida. The chapter defines the "practice of medicine" to mean the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition.[17] The Board of Medicine is authorized to adopt rules to implement provisions of the medical practice act and discipline medical physicians.[18]

The Practice of Osteopathic Medicine

Chapter 459, F.S., also known as the osteopathic medicine practice act, governs the practice of osteopathic medicine. The chapter defines the "practice of osteopathic medicine" to mean the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition, which practice is based in part upon educational standards and requirements which emphasize the importance of the musculoskeletal structure and manipulative therapy in the maintenance and restoration of health.[19] The Board of Osteopathic Medicine has the authority to adopt rules to implement provisions of the osteopathic medicine practice act, and discipline osteopathic physicians.[20]

C. SECTION DIRECTORY:

Section 1. Creates s. 458.3175, F.S., relating to expert witness certificate.

Section 2. Creates paragraph (oo) of subsection (1) of s.458.331, F.S., relating to grounds for disciplinary action.

Section 3. Creates s. 459.0066, F.S., relating to expert witness certificate.

Section 4. Creates paragraph (qq) of subsection (1) of s. 459.015, F.S., relating to grounds for disciplinary action.

Section 5. Creates subsection (12) and renumbers existing subsection (12) of s.766.102, F.S., relating to medical negligence; standards of recovery; expert witness.

Section 6. Provides an effective date of October 1, 2006.

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[17] s 458.305(3), F.S.,
[18] ss. 458.309, and 458.331, F.S .
[19] s. 459.003, F.S.,
[20] ss. 459.005, and 459.015, F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The Department of Health should generate revenue as a result of the application fee required to secure an expert witness certificate.

2. Expenditures: According to DOH the cost associated with this bill is as follows:

Estimated Expenditures	FY 2006/2007	FY 2007/2008 (Annualized/Recurr.)
Salaries		
1 Research Specialist (RS) II, PG 17 (BOM) (not lapsed)	$38,550	$38,550
2 RS II, PG 17 (BMS)	$57,825	$77,100
1 Information Specialist (IS) II, PG 20 (CSU)	$33,851	$45,135
2 RS I, PG 15, (BMS)	$52,758	$70,344
1 IS II, PG 20 (ISU)	$33,851	$45,135
1 Admin Asst, PG 15 (BMS)	$26,379	$35,172
Other Personal Services		
Expert Witness fees to review disciplinary cases	$20,000	$20,000
Expense		
Non-recurring expense package	$25,088	
Recurring expense package with limited travel for one RS II	$10,390	$10,390
Recurring expense package with maximum travel for two IS II	$31,514	$31,514
Recurring expense package with no travel for two RS II	$12,806	$12,806
Recurring expense	$15,585	$15,585
Operating Capital Outlay		
OCO package for new FTEs	$15,800	
Human Resource Services		
For new FTEs	$3,144	$3,144
Total Estimated Expenditures	$377,541	$404,875

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

An expert witness who resides in a state other than Florida or in Canada would need to secure a certificate to provide expert testimony in Florida and would incur an application fee for the certificate of no greater than $50.

D. FISCAL COMMENTS:

According to DOH, because the bill creates two new regulatory programs (one in the Board of Medicine and one in the Board of Osteopathic Medicine), it necessitates additional staff to administer. DOH computed salaries at 10% above the minimum for the pay grade plus 28% for benefits and all positions were lapsed at 25% except for the Board of Medicine position.

- Two positions are needed for the Compliance Monitoring Unit in the Bureau of Management Services to handle the expected multiple requests for certification and public documents and the increased monitoring of new disciplinary actions.
- Two positions are needed in the Central Records Unit in the Bureau of Management Services due to the expected increase in the clerk's filing of documents, reporting to the Federation of State Medical Boards, public records requests (general public and state), certification of disciplinary files and orders, and certification of licensure orders and appeals processed.
- One position is required for the Federal Health Care Integrity Protection Data Bank (HIPDB) unit to handle increased federally mandated reporting of board actions.
- One position is required for the Investigative Services Unit to absorb the anticipated investigative workload.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take any action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The bill provides authority to the Florida Board of Medicine and the Board of Osteopathic Medicine to adopt rules to implement expert witness certificate requirements.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, 2006, the Health Care General Committee adopted four amendments to the bill as delineated below:

- Amendment #1 defines an expert witness certificate as a license for the purpose of disciplinary action under chapter 458, F.S., and thus requiring that the procedures, protections and due

process provisions afforded to a licensed physician in a disciplinary action also apply to the holder of an expert witness certificate.

- Amendment #2 defines an expert witness certificate as a license for the purpose of disciplinary action under chapter 459, F.S., and thus requiring that the procedures, protections and due process provisions afforded to a licensed osteopathic physician in a disciplinary action also apply to the holder of an expert witness certificate.
- Amendment #3 moves the effective date of the act to October 1, 2006 to give the Board of Medicine and the Board of Osteopathic Medicine more time to promulgate rules, develop forms and hire staff to administer the expert witness certificate programs.
- Amendment #4 corrects a cross reference regarding the definition of osteopathic medicine.

The bill was reported favorably with a committee substitute.

This analysis reflects the bill as amended.

CHAMBER ACTION

The Health Care General Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to expert witnesses; creating ss. 458.3175 and 459.0066, F.S.; requiring the Board of Medicine and the Board of Osteopathic Medicine, respectively, to issue expert witness certificates to certain licensed physicians under certain circumstances; providing requirements for certification; providing a limitation; requiring the boards to implement rules and set fees; amending ss. 458.331 and 459.015, F.S.; providing that certain fraudulent, deceptive, or misleading expert witness testimony is grounds for disciplinary action; providing penalties; amending s. 766.102, F.S.; providing that certain medical expert testimony is not admissible unless the expert witness meets certain requirements; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 458.3175, Florida Statutes, is created to read:

458.3175 Expert witness certificate.--

(1) Any physician who is licensed to practice allopathic medicine in any other state or in Canada, whose license is currently active and valid, who completes a registration form prescribed by the board, who pays the application fee, and who has not had a previous expert witness certificate revoked by the board shall be issued a certificate to provide expert testimony. For the purpose of this section, an expert witness certificate shall be considered a license as defined in s. 456.001 and treated as a license in any applicable disciplinary action pursuant to this chapter.

(2) A physician possessing an expert witness certificate may use the certificate solely to give a verified written medical expert opinion as provided in s. 766.203 and to provide expert testimony concerning the prevailing professional standard of care in connection with any medical negligence litigation pending in this state against a physician licensed under this chapter or chapter 459. The possession of an expert witness certificate alone does not entitle the physician to engage in the practice of medicine as defined in s. 458.305.

(3) Every application for an expert witness certificate shall be approved or denied within 5 business days after receipt of a completed application. Any application for a certificate that is not approved or denied within the required time period is considered approved. Any applicant for an expert witness certificate seeking to claim certification by default shall

notify the board, in writing, of the intent to rely on the default certification provision of this subsection.

(4) All licensure fees other than the initial application fee, including neurological injury compensation assessments, shall be waived for those persons obtaining an expert witness certificate but not otherwise allowed to practice medicine in this state.

(5) The board shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, including rules setting the amount of the expert witness certificate application fee. The application fee for the expert witness certificate may not exceed $50. An expert witness certificate shall expire 2 years after the date of issuance.

Section 2. Paragraph (oo) is added to subsection (1) of section 458.331, Florida Statutes, to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(oo) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine.

Section 3. Section 459.0066, Florida Statutes, is created to read:

459.0066 Expert witness certificate.--

(1) Any physician who is licensed to practice osteopathic medicine in any other state or in Canada, whose license is currently active and valid, who completes a registration form prescribed by the board, who pays the application fee, and who

has not had a previous expert witness certificate revoked by the board shall be issued a certificate to provide expert testimony. For the purpose of this section, an expert witness certificate shall be considered a license as defined in s. 456.001 and treated as a license in any applicable disciplinary action pursuant to this chapter.

(2) A physician possessing an expert witness certificate may use the certificate solely to give a verified written medical expert opinion as provided in s. 766.203 and to provide expert testimony concerning the prevailing professional standard of care in connection with any medical negligence litigation pending in this state against a physician licensed under this chapter or chapter 458. The possession of an expert witness certificate alone does not entitle the physician to engage in the practice of osteopathic medicine as defined in s. 459.003.

(3) Every application for an expert witness certificate shall be approved or denied within 5 business days after receipt of a completed application. Any application for a certificate that is not approved or denied within the required time period is considered approved. Any applicant for an expert witness certificate seeking to claim certification by default shall notify the board, in writing, of the intent to rely on the default certification provision of this subsection.

(4) All licensure fees other than the initial application fee, including neurological injury compensation assessments, shall be waived for those persons obtaining an expert witness certificate but not otherwise allowed to practice osteopathic medicine in this state.

(5) The board shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, including rules setting the amount of the expert witness certificate application fee. The application fee for the expert witness certificate may not exceed $50. An expert witness certificate shall expire 2 years after the date of issuance.

Section 4. Paragraph (qq) is added to subsection (1) of section 459.015, Florida Statutes, to read:

459.015 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(qq) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine.

Section 5. Subsection (12) of section 766.102, Florida Statutes, is renumbered as subsection (13), and a new subsection (12) is added to that section to read:

766.102 Medical negligence; standards of recovery; expert witness.--

(12) If the party against whom or on whose behalf the expert testimony concerning the prevailing professional standard of care is offered is a physician licensed under chapter 458 or chapter 459, the expert witness must be licensed in this state under chapter 458 or chapter 459 or possess an expert witness certificate as provided in s. 458.3175 or s. 459.0066. Expert testimony is not admissible unless the expert providing such testimony is licensed by this state or possesses an expert witness certificate.

Section 6. This act shall take effect October 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7125 PCB HCR 06-04 Electronic Prescribing
SPONSOR(S): Health Care Regulation Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care Regulation Committee	10 Y, 0 N	Bell	Mitchell
1) Health Care Appropriations Committee	14 Y, 0 N	Money	Massengale
2) Health & Families Council		Bell AJB	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

With rapid change in new information technologies the development of electronic prescribing practices is integral to the achievement of state and national goals for electronic medical records. Current regulations regarding written prescriptions are problematic for prescriptions electronically generated.

House Bill 7125 allows for the development and regulation of electronic prescribing practices and provides protections for consumers. It creates one new provision in state statute and amends four others.

The bill defines "records custodians" and provides that all those with access to medical or prescription records abide by confidentiality and disclosure requirements. The bill establishes information that must be contained in electronic prescriptions. The bill regulates the use of electronic prescribing software and forbids that such software interfere with prescribing decisions at the point of care, or direct practitioners toward choosing particular pharmacies. Finally, the bill provides mechanisms to ensure that patients receive brand name drugs, when such drugs are medically necessary, and not substitutes, when prescribed electronically.

According to the Department of Health, there is no fiscal impact to implement the provisions in this bill.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government - The bill removes regulatory barriers to streamline the process of prescribing prescription drugs electronically.

Safeguard Individual Liberty - The bill protects the rights of consumers and their health care providers to determine appropriate pharmaceuticals, to purchase from pharmacies of their choice, and to guarantee the confidentiality of medical records and prescriptions.

B. EFFECT OF PROPOSED CHANGES:

PRESENT SITUATION

Florida law permits electronic prescriptions under chapter 456, F.S., and authorizes the regulation of the practice of pharmacy by the Florida Board of Pharmacy. Section 465.003(14), F.S., further defines "prescription" to be any order for drugs or medicinal supplies written or transmitted by any means of communication by a licensed practitioner and intended to be dispensed by a pharmacist. Prescriptions may be transmitted from practitioners to pharmacies orally or through writing; and pharmacies may transfer prescriptions by any means, including electronic, under specified conditions.

Medical Records

Currently, only certain health care practitioners and their employers (if agreed by contract) are considered records owners and subject to limitations on the handling of patient medical records under s. 456.072, F.S. Other individuals who later come into possession of patient medical records are not subject to these limitations.

Legible Prescribing Law

The Legible Prescribing Law, codified in s. 456.42, F.S., requires that all written prescription drugs must:

- Be legibly printed or typed;
- Contain the name of the prescribing practitioner;
- Contain the name and strength of the drug, the quantity of the drug in both textual and numerical formats;
- Contain directions for use;
- Be dated and signed with the month written in textual letters; and
- Be signed by the prescribing practitioner on the day when issued.

To fill a written prescription, Florida law requires that the prescription be signed by the prescribing practitioner. This poses a problem for electronically generated prescriptions.

Generic Substitution

Currently, under s. 456.025, F.S., a pharmacist may substitute a generic drug for a brand name drug when any written prescription does not include the words, MEDICALLY NECESSARY written by the prescribing practitioner. It is technically difficult for the prescribing practitioner to write on electronically generated prescriptions.

EFFECTS OF THE BILL

Electronic prescribing is integral to the achievement of state and national goals for integrated electronic medical records. The bill creates one and amends four provisions in state statute for the development of electronic prescribing practices, the regulation of electronic prescribing software, and the protection of patient rights.

Definition of Records Custodian

House Bill 7125 amends s. 456.057, F.S., to define "records custodian" and to require records custodians and records owners to maintain records and documents as provided under the confidentiality and disclosure requirements of this section. The bill provides that all those with access to medical or prescription records abide by confidentiality and disclosure requirements. According to the Department of Health (DOH), this helps address confidentiality concerns when patient medical records are abandoned by the practitioner. This provision is subject to enforcement by the Office of Attorney General through injunctive relief and fines of up to $5,000 per violation.

Requirements for Electronic Prescriptions

The bill amends s. 456.42, F.S., to provide requirements for prescriptions that are electronically generated and transmitted. The bill requires that the electronic prescription contain the name of the prescribing practitioner, name and strength of the drug prescribed, quantity of the drug prescribed in numerical format (in contrast to handwritten prescriptions that require both textual and numerical format), directions for use of the drug, date, and signature by practitioner only on the day issued. The signature may be in an electronic format as defined by s. 668.003(4), F.S.

Consumer Choice of Pharmacy

The bill creates s. 456.43, F.S., to regulate electronic prescribing software for the protection of consumers and patient's rights. As electronic prescribing becomes more prevalent it is necessary to protect consumer choice when choosing a pharmacy. This section provides restrictions and establishes that electronic prescribing software:

- Shall not interfere with patient's freedom to choose a pharmacy.
- Shall not attempt to influence, through economic incentives or otherwise, the prescribing decision of a physician at the "point of care"—the time that the practitioner or agent is in the act of prescribing a certain pharmaceutical or directing a patient to a certain pharmacy.
- Shall be permitted to show information regarding a payor's formulary as long as nothing is designed to preclude or make more difficult the act of the patient or physician selecting any particular pharmacy or pharmaceutical.

Protections against Generic Substitution of Brand Name Drugs

The bill amends s. 456.025, F.S., to provide mechanisms to ensure that patients receive brand name drugs and not generic substitutes, when brand name drugs are medically necessary. The bill ensures that a pharmacist may fill electronically generated prescriptions with the brand name drug if the prescription reflects that it is medically necessary without requiring the prescribing practitioner to write the words, MEDICALLY NECESSARY.

The effective date of the bill is July 1, 2006.

BACKGROUND

Electronic prescribing (e-prescribing) uses computers and automated data systems rather than handwritten communications to generate prescriptions, and is the future standard practice in prescription writing. Although e-prescribing rates today vary between 5 percent and 18 percent for physicians, usage is increasing[1] because of initiatives at the national and state levels, and because of independent efforts by health care providers and pharmacists. In June 2005, President Bush called for most Americans to have electronic health records[2] within ten years. The Florida Health Information Network was developed by the Agency for Health Care Administration (AHCA) to facilitate the development of a statewide privacy-protected health information infrastructure network as recommended by the Governor's Health Information Infrastructure Advisory Board. The program has received funding from the Florida Legislature to support personnel and grant programs aimed at developing regional health information exchanges and to encourage the use of electronic health records.[3] Electronic prescribing is an integral component in the fulfillment of these national and state goals.

Concerns with patient safety, the efficiency of care, and integrated medical records are the key objectives driving efforts for electronic prescribing. More than 4 billion prescriptions are written each year[4] and therefore even small improvements in the prescribing process will translate into significant healthcare cost and safety benefits. Studies suggest that the national savings from universal adoption of electronic prescribing systems could be as high as $27 billion, because of a combination of injury prevention, better utilization of drugs,[5] and efficiency both at the point of care and subsequent to treatment.

Security Measures Used by Electronic Prescribing Networks

Currently, there are a number of methods through which electronic networks secure confidentiality and data integrity. These features include credentialing, where prescribers and pharmacies are enrolled in a network through access authorization; user ID and password for authentication and access to electronic prescribing software; the use of network-assigned electronic signatures; and the transmission of prescription messages through a private leased line or through the Internet using a virtual private network connection or protocol.[6]

Benefits of Electronic Prescribing

Reduction of potential errors of handwriting and transcription

The prescribing process is error-prone. Adverse drug events (ADE) are the fourth leading cause of death[7] and cost as much as $136 billion a year.[8] Among ADEs, 7,000 deaths a year are attributed to prescription error.[9] Causes of errors include illegible handwriting, wrong dosage, and the overlooking of dangerous drug-drug or drug-allergy interactions. Medication errors further account for 1 out of 131 ambulatory care deaths.[10] As a solution for a portion of these errors, computer-assisted prescriptions

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[1] Ferris, Nancy. 11/2/05. "CMS finalizes e-prescribing rules." *Government Health.* www.govhealthit.com/article91285-11-02-05-Web.
[2] According to the Florida Senate Interim Project 2006-135, "An electronic health record is a digital collection of information from a patient's medical history that may include diagnoses, prescribed medications, vital signs, immunizations, and personal characteristics."
[3] Agency for Health Care Administration press release, January 6, 2006; http://www.fdhc.state.fl.us/dhit/press_release.shtml.
[4] AllScripts analysis of e-prescribing at http://www.allscripts.com/slnsClnclnfo.aspx
[5] Agency for Healthcare Research and Quality. MEPS Highlights #11: Distribution of health care expenses, 1999.
[6] National Committee on Vital and Health Statistics. http://www.cdc.gov/nchs/data/ncvhs/nchvs50th.pdf
[7] Committee on Quality of Health Care in America: Institute of Medicine. "To err is human: building a safer health system." Washington, D.C.: National Academy Press, 2000.
[8] Lazarou, J., Pomeranz, B., Corey, PN. "Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies. *JAMA*. 1998; 279:1200-1205.
[9] Johnson, JA., Bootman, JL. "Drug-related morbidity and mortality: a cost-of-illness model." *Arch Intern Med.* 1995; 155:1949-1956.
[10] "Electronic Prescribing: Toward Maximum Value and Rapid Adoption." A report of the *Electronic Prescribing Initiative.* Washington, D.C., April 14, 2004.

have been shown to cut errors by 70 percent over handwritten prescriptions.[11] In addition to improving the readability of scripts and the accuracy of transcription from the prescription to the pharmacy, a reduction in errors accomplished by electronic prescribing is due to information made available to doctors about the correct dosage, use instructions, and other aspects of the prescription. At the point of care, electronic prescribing systems can provide an overall medication management process by performing checks against the patient's current medications, duplicate therapies, medical history, diagnoses, body weight, age, and more. The system then alerts the physician if problems are found.

Integration of prescription information into the electronic medical record

Electronic prescribing can further contribute to the integration of the prescription into a patient's consolidated medical record. Access to information about a patient's formulary can guide physicians to consider formulary-based drug coverage, including on-formulary alternatives and co-pay information. By checking with healthcare formularies at point-of-care, generic substitutions and generic first-line therapy choices are encouraged, thus reducing patient costs.

Efficiency

Electronic prescribing increases efficiency for physicians, patients, and pharmacists. At the point-of-care, electronic prescribing saves time for the physician's staff. For many practitioners, it is quicker to e-prescribe than to have a nurse spend time calling in a refill for the drug.[12] Physicians can expect fewer callbacks from pharmacies to clarify prescription details and refill renewal authorizations that are completed in a fraction of the time, so that more time can be dedicated to patient care and other activities.[13] A 2003 survey of Boston area physicians found that 88 percent of those surveyed reported that they and their staff spend almost one-third of their time responding to phone calls from pharmacies regarding prescriptions, and that these call-backs interrupt office flow and reduce productivity related to chart-pulls, re-filing charts, faxing prescriptions, and so on.[14] For patients, electronic prescribing means eliminated or significantly reduced waiting times at pharmacies.[15] Benefits in efficiency for pharmacists are also significant. Because all necessary prescription information is transmitted and received, more time can be spent with customers. Electronic prescribing improves record keeping, reduces phone calls and faxes, and more readily alerts pharmacists to possible drug contraindications within a patient's file. Approximately, 900 million prescription-related calls are made annually, for refills, questions and clarifications; and electronic prescribing reduces the expense of this for all parties.[16]

Protecting Against Abuses of Electronic Prescribing

Although electronic prescribing does have the demonstrated potential to save lives, time, and money, unsecured systems could lead to forgery, fraud, unfair trade practices, or the loss of patient confidentiality. In developing electronic programs it is critical that precautions be taken to expand consumer protection. Among these measures, the patient's right to choose medications and pharmacies should be protected; and therefore, software used in electronic prescribing should be prevented from directing the practitioner toward specific medications or pharmacies through pop-up ads or marketing of any other kind. Patient confidentiality must also be protected; and therefore, electronic data services ("records custodians") should be bound by the same specified requirements for confidentiality and disclosure as pharmacies and physicians already are. It is also important that

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[11] "HHS Accelerates Use of E-Prescribing and Electronic Health Records." *Press Release from the US Department of Health and Human Services.* 11/5/2005. http://biz.yahoo.com/prnews/051005/dcw035.html?.v=29&printer=1.

[12] Baldwin, Gary. 10/17/2005. "E-prescribing eliminates wait." *Health Leaders.* http://www..healthleaders.com/news/print.php?contentid=73529.

[13] Institute of Medicine, Center for Information Technology Leadership, in Walgreens presentation on e-prescribing.

[14] "Boston Area Physicians Embrace E-Prescribing Technology as a Tool To Improve Healthcare". Medco Health Solutions, Inc. – News and Pressroom article on 2/7/2003. http://www.corporate-ir.net/ireye/ir_site.zhtml?ticker=MHS&script=410&layout=-6&item_id=442064

[15] Baldwin, Gary. 10/17/2005. "E-prescribing eliminates wait." *Health Leaders.* http://www..healthleaders.com/news/print.php?contentid=73529.

[16] Healthcare Information and Management Systems Society at http://www.himss.org/ASP/topics_eprescribing.asp.

electronic prescriptions include the same level of information as paper prescriptions; detailing patient and physician names, drug name and strength, quantity and directions for use of the drug, date, electronic signature, and an option to prevent automatic substitution of brand name drugs with generic drugs in cases where the brand name drug is medically necessary for the patient.

Expansion of Electronic Prescribing in Medicare and Florida Medicaid

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, electronic-prescribing is optional for physicians and pharmacies. However, starting on January 1, 2006, drugs covered under Medicare Part D are required to support electronic prescribing.[17] The Act has also called for the creation of a grant program that supports the implementation and adoption of electronic prescribing technology beginning in 2007.

The Florida Medicaid program has used an electronic prescribing system since the summer of 2002. Three thousand of the state's highest prescribing (by volume) physicians were given interactive handheld computers that load information on drugs, formularies, and the previous 100 days of prescription history. This represents physicians writing 80 percent of all Medicaid prescriptions in FL, which involves approximately 25 million transactions per year.[18] Florida Medicaid program staff estimate that about $2 million is saved each month by the use of the electronic prescribing system, and that the program has also demonstrated the potential for electronic prescribing to save lives.[19]

C. SECTION DIRECTORY:

Section 1. – Amends s. 456.057, F.S., to provide definitions for "records custodian" and to require records custodians and records owners to maintain records and documents as provided under the confidentiality and disclosure requirements of the section.

Section 2. – Amends s. 456.42, F.S., to provide requirements for prescriptions that are electronically generated and transmitted.

Section 3. – Creates s. 456.43, F.S., to regulate electronic prescribing software for the protection of consumers and patient's rights.

Section 4. – Amends s. 456.025, F.S., to prevent the substitution of generic drugs when brand name drugs are medically necessary, when a prescription is electronically transmitted and generated.

Section 5. – Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[17] For complete standards see "Government announces ePRESCRIPTION standards for drug plans" by Caroline Broder, Healthcare IT News. 11/2/2005. www.healthcareitnews.com/NewsArticleView.aspz?ContentID=3940.
[18] Roop, Liz. 2005. "State by state programs" eMPOWEPrescription. www.gsm.com, or 813-258-4747.
[19] The Florida Senate Interim Project Report 2006-135.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rulemaking authority to implement the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to medical records; amending s. 456.057, F.S.; providing definitions; requiring a health care practitioner's employer who is a records owner and a records custodian to comply with specified requirements for confidentiality and disclosure; amending s. 456.42, F.S.; providing requirements for prescriptions of medicinal drugs by health care practitioners that are electronically generated and transmitted; creating s. 456.43, F.S.; regulating electronic prescribing for medicinal drugs; providing restrictions for electronic prescribing software; providing definitions; authorizing electronic prescribing software to show information regarding a payor's formulary under certain circumstances; amending s. 465.025, F.S.; specifying requirements for a prescriber to prevent generic substitution for brand name drugs when a prescription is electronically transmitted and generated; amending s. 381.028, F.S.; correcting a cross-reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (3) through (19) of section 456.057, Florida Statutes, are renumbered as subsections (5) through (21), respectively, and new subsections (3) and (4) are added to that section to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished.--

(3) As used in this section, the term "records custodian" means any person or entity that:

(a) Maintains documents that are authorized in subsection (2); or

(b) Obtains medical records from a records owner.

(4) Any health care practitioner's employer who is a records owner and any records custodian shall maintain records or documents as provided under the confidentiality and disclosure requirements of this section.

Section 2. Section 456.42, Florida Statutes, is amended to read:

456.42 Written prescriptions for medicinal drugs.--A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in both textual and numerical formats, and the directions for use of the drug; must be dated with the month written out in textual letters; and must be signed by the prescribing practitioner on the day when issued. However, a prescription that is electronically generated and transmitted must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in numerical format, and the directions for use of the drug and must be dated and signed by the prescribing practitioner only on the day issued, which signature may be in an electronic format

as defined by s. 668.003(4).

Section 3. Section 456.43, Florida Statutes, is created to read:

456.43 Electronic prescribing for medicinal drugs.--

(1) Electronic prescribing shall not interfere with a patient's freedom to choose a pharmacy.

(2) Electronic prescribing software shall not use any means or permit any other person to use any means, including, but not limited to, advertising, instant messaging, and pop-up ads, to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a physician at the point of care. Such means shall not be triggered or in specific response to the input, selection, or act of a physician or his or her agent in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy.

(a) The term "prescribing decision" means a physician's decision to prescribe a certain pharmaceutical or direct a patient to a certain pharmacy.

(b) The term "point of care" means the time that a physician or his or her agent is in the act of prescribing a certain pharmaceutical or directing a patient to a certain pharmacy.

(3) Electronic prescribing software may show information regarding a payor's formulary as long as nothing is designed to preclude or make more difficult the act of a physician or patient selecting any particular pharmacy or pharmaceutical.

Section 4. Subsection (2) of section 465.025, Florida Statutes, is amended to read:

465.025 Substitution of drugs.--

(2) A pharmacist who receives a prescription for a brand name drug shall, unless requested otherwise by the purchaser, substitute a less expensive, generically equivalent drug product that is:

(a) Distributed by a business entity doing business, and subject to suit and service of legal process, in the United States; and

(b) Listed in the formulary of generic and brand name drug products as provided in subsection (5) for the brand name drug prescribed,

unless the prescriber writes the words "MEDICALLY NECESSARY," in her or his own handwriting, on the face of a written prescription; ~~or~~ unless, in the case of an oral prescription, the prescriber expressly indicates to the pharmacist that the brand name drug prescribed is medically necessary; or unless, in the case of a prescription that is electronically generated and transmitted, the prescriber makes an overt act when transmitting the prescription to indicate that the brand name drug prescribed is medically necessary. When done in conjunction with the electronic transmission of the prescription, the prescriber's overt act indicates to the pharmacist that the brand name drug prescribed is medically necessary.

Section 5. Paragraph (c) of subsection (7) of section 381.028, Florida Statutes, is amended to read:

381.028 Adverse medical incidents.--

(7) PRODUCTION OF RECORDS.--

(c)1. Fees charged by a health care facility for copies of records requested by a patient under s. 25, Art. X of the State Constitution may not exceed the reasonable and actual cost of complying with the request, including a reasonable charge for the staff time necessary to search for records and prevent the disclosure of the identity of any patient involved in the adverse medical incident through redaction or other means as required by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations. The health care facility may require payment, in full or in part, before acting on the records request.

2. Fees charged by a health care provider for copies of records requested by a patient under s. 25, Art. X of the State Constitution may not exceed the amount established under s. 456.057(18) ~~(16)~~, which may include a reasonable charge for the staff time necessary to prevent the disclosure of the identity of any patient involved in the adverse medical incident through redaction or other means as required by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations. The health care provider may require payment, in full or in part, before acting on the records request.

Section 6. This act shall take effect July 1, 2006.

HB 7125 Amendment by Rep. Garcia

The amendment conforms the bill to the Senate bill. The amendment:

- Changes physician to prescribing practitioner;
- Removes unnecessary language; and
- Add language to protect utilization management tools used in the prescription drug prescribing process.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No._____(for drafter's use only)

Bill No. **HB 7125**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Garcia offered the following:

Amendment (with directory and title amendments)

Remove line(s) 67-82 and insert:

incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care. Such means shall not be triggered or in specific response to the input, selection, or act of a prescribing practitioner or his or her agent in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy.

(a) The term "prescribing decision" means a prescribing practitioner's decision to prescribe a certain pharmaceutical.

(b) The term "point of care" means the time that a prescribing practitioner or his or her agent is in the act of prescribing a certain pharmaceutical or directing a patient to a certain pharmaceutical.

(3) Electronic prescribing software may show information regarding a payor's formulary as long as nothing is designed to preclude or make more difficult the acts of a practitioner in

prescribing any particular pharmaceutical or a patient in selecting a particular pharmacy.

(4) This section does not limit a payor or provider from implementing utilization management tools including, but not limited to, utilization review, a quality assurance program, a continuity of care system, a disease management system, step therapy or prior authorization system.